2004-2005 Employee Benefits Guide

County of San Bernardino
Employee Benefits & Services
Active Employees

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Questions?

This booklet is designed to help you discover your options during Open Enrollment. It is intended to highlight your benefits and does not fully represent all of the terms of your benefits program. Nothing in this booklet creates an express or implied contract of employment between the County and its employees.

As You Enroll

Introduction

This booklet is designed to help you understand your Benefit Enrollment options. Included are summaries of your plan choices, including medical, dental, life insurance, AD&D and retirement options. You will also find comparison charts for convenient at-a-glance referencing and plan contact information. Please read your materials carefully, then choose the plans that best meet your needs.

As you prepare to enroll or make changes in your coverage, consider your benefits needs carefully. Think about the types and levels of coverage that you might need, both now and throughout the plan year. And don't forget to factor costs into your benefits picture.

We encourage you to keep this booklet as a reference throughout the year. If you have questions, contact Employee Benefits and Services or the plan directly. Plan phone numbers and web sites are listed in the Contact Information section of this booklet.

This booklet only highlights your benefits. It is not a summary plan description (SPD). Official plan and insurance documents actually govern your rights and benefits under each plan. If any discrepancy exists between this booklet and the official documents, the official documents will prevail.

What's New & Different in 2004

There are several significant changes for the 2004/2005 Plan Year.

◆ **Introducing eBenefits, on-line Open Enrollment.** eBenefits offers you self-service in managing your own benefits and allows you to complete your enrollment from home or work, view your choices immediately for accuracy and print your own confirmation statement.

◆ **State-mandated Domestic Partner benefit coverage will begin on December 25, 2004.** If you are currently in a State Registered Domestic Partnership you may enroll your Domestic Partner and your Domestic Partner's dependent children in a County-sponsored Medical, Dental, and/or Vision Plan (if eligible) during the 2004 Open Enrollment period. *Coverage will not be effective until December 25, 2004.* You cannot use eBenefits to enroll your Domestic Partner or your Domestic Partner's children, you must manually enroll them by completing a paper enrollment form. If you have questions or need enrollment forms, please contact Employee Benefits and Services at (909) 387-5787.

◆ The State of California defines Domestic Partners as members of the same sex or opposite sex when one or both partners are over the age of 62 and meet the eligibility criteria under Title II or Title XVI of the Social Security Act. For additional information regarding Domestic Partner registration, please contact the State of California's Los Angeles Regional Office, 300 S. Spring St., Room 12513, Los Angeles, CA 90013-1233, (213) 897-3062, or the Domestic Partner Registry web site, www.ss.ca.gov/dpregistry/. The Employee Benefits and Services Division cannot assist you with Domestic Partner registration issues or questions as it is a state program.

◆ Employees on an approved leave of absence who want to make Open Enrollment changes must contact Employee Benefits and Services Division at (909) 387-5787.

◆ The escalating cost of healthcare is a national crisis with employers again facing double digit premium increases this year. It is expected that this trend will continue over the next several years. The Employee Benefits and Services Division is committed to seeking alternative solutions to this continuing problem, and will continue to keep employees advised.

Please read this section for a summary of all key benefit changes for 2004/2005.

REMINDERS! To continue your Opt-Out election, a new Opt-Out form must be completed and submitted each Open Enrollment with proof of other group coverage attached. Opt-Out forms are available on-line, through your department payroll clerk, or by calling Employee Benefits and Services Division at (909) 387-5787.

To renew your Medical Expense Reimbursement (FSA) Plan, you must re-enroll through eBenefits.

Proof of Dependent Eligibility Required for Newly Enrolled Dependents

To enroll a new dependent under your County plans, you must submit proof of your dependent's eligibility.

Additionally, if a dependent aged 19 to 23, is a full-time student or is mentally or physically disabled and aged 19 or over, a "Student or Disabled Dependent Certification Form" needs to be completed. If you do not provide proof when required, your dependents will not be covered for the next plan year.

Health Net

There are no significant benefit changes to the County's Health Net ELECT Open Access Plan for 2004/2005. Please refer to the enclosed Premium Rate Table and Medical Plans Comparison Chart for specific information.

Kaiser Permanente

There are no significant benefit changes to the County's Kaiser Permanente Plan for 2004/2005. Please refer to the enclosed Premium Rate Table and Medical Plans Comparison Chart for specific information.

Blue Cross

There are no significant benefit changes to the County's Blue Cross Plan for 2004/2005. Please refer to the enclosed Premium Rate Table and Medical Plans Comparison Chart for specific information.

DeltaPreferred

DeltaPreferred will now pay 90% for basic services (preventive care, restorative dentistry, periodontics, endodontics, and oral surgery), instead of 80%. Participants will re responsible for a copayment of 10% for these services. The

Read Your Enrollment Materials

The purpose of the previous section is to give you an overview of some of the key changes in your 2004 benefits program. For details, be sure to read your enrollment materials carefully. Open Enrollment is June 1 through June 30, 2004.

lifetime maximum for orthodontia expenses has increased to $1,500. The calendar year benefit maximum has increased to $1,500 per person (excluding orthodontia). **If you enroll in the DeltaPreferred plan, you must remain in the plan for a minimum of two (2) years.**

Delta Care

There are no significant benefit changes to the County's Delta Care Plan for 2004/2005. Please refer to the enclosed Premium Rate Table and Dental Plans Comparison Chart for specific information.

Voluntary Term Life Insurance Plan and AD&D

There are no significant benefit changes to the County's Voluntary Term Life Insurance Plan and AD&D Plan for 2004/2005. Premium costs have remained the same.

Variable Universal Life (VUL) Insurance Plan

There are no significant benefit changes to the County's Variable Universal Life Insurance Plan for 2004/2005. For more information on this plan, please call AGB at (866) 956-1876.

Medical Expense Reimbursement (FSA) Plans

Due to an Internal Revenue Service (IRS) ruling, some nonprescription (over-the-counter) medications may now be reimbursed under a health FSA. For more information, please refer to the enclosed plan highlights, the Medical Expense Reimbursement Plan Documents, or go online at http://countyline/hr/benefits/fsa_plan.asp.

Short-Term Disability (STD) Plan

The maximum weekly benefit amount for the County's STD plan has increased. For more information on this plan, please refer to the enclosed plan highlights, the Short-Term Disability Plan Documents, or go online at http://countyline/hr/benefits/short_term_disability.asp.

Vision Plan

There are no significant changes to the County's Vision Plan for 2004/2005.

2004 Open Enrollment Master Schedule

JUNE	1	Tues	Open Enrollment begins! Informational meetings are scheduled throughout the County. Check the meeting schedule included in this booklet for locations, dates and times. During Open Enrollment, if you are eligible, you may: ◆ Change medical and/or dental plans ◆ Add eligible dependents to your medical and/or dental plans ◆ Drop dependents from your medical and/or dental plans ◆ Opt-Out of a County-sponsored medical plan and/or dental plan (other comparable group coverage required) ◆ Change your refundable/nonrefundable retirement contribution election ◆ Enroll in Voluntary Term Life, Variable Universal Life, Accidental Death and Dismemberment (AD&D) insurance, and/or Medical Expense Reimbursement Plan ◆ Change your Benefit Plan and Premium Conversion Option elections **NOTE: EVERY EMPLOYEE MAKING CHANGES, NEWLY OPTING-OUT OR ENROLLING IN THE MEDICAL EXPENSE REIMBURSEMENT PLAN MUST COMPLETE THE eBENEFITS ONLINE OPEN ENROLLMENT.**
JUNE	7-11		eBenefits sessions available for computer access and one-on-one assistance. Monday-Friday, 8:00 a.m. to 5:00 p.m. at PERC Mountain View Center, 504 North Mt. View Avenue, San Bernardino, CA and PERC Victorville Center, 17270 Bear Valley Road, Suite 107, Victorville, CA.
JUNE	9	Wed	*Open Enrollment Health Fair* 9:00 a.m. to 3:00 p.m., County Government Center, 385 N. Arrowhead Ave., Rotunda, San Bernardino, CA
JUNE	24	Thurs	*Open Enrollment Health Fair* 9:00 a.m. to 3:00 p.m., Green Tree Inn, 14173 Green Tree Blvd., Victorville, CA.
JUNE	30	Wed	*Open Enrollment ends!* This is the deadline to submit your 2004 Benefits Elections.
JULY	24	Sat	Effective date of coverage for changes made to medical, dental, voluntary term life, and AD&D plans.
AUG	5	Thurs	Pay warrants reflect Open Enrollment rate changes.
AUG	6	Fri	Confirmation Statements mailed to all employees.
AUG	27	Fri	Deadline to contact Employee Benefits and Services to report any errors or discrepancies on your Confirmation Statement.

2004 Open Enrollment Meeting Schedule

Benefits are an important part of your total compensation package. Take advantage of this opportunity to discover your options. The County has arranged to have insurance plan representatives on-site to answer your questions.

DATE	DAY	TIME	CITY	LOCATION
JUN 1	Tue	9:00 a.m. & 10:30 a.m.	Hesperia	TAD, 9655 9th Ave., Conference Room D
		1:30 p.m. & 3:00 p.m.	Victorville	TAD, 12219 2nd Ave., Conference Room
JUN 2	Wed	9:00 a.m. & 10:30 a.m.	Victorville	Behavioral Health, 12625 Hesperia Rd. Club House
		1:30 p.m. & 3:00 p.m.	Victorville	Child Support Services 15456 Sage St., Break Room
JUN 3	Thu	9:00 a.m. & 10:30 a.m.	Loma Linda	Child Support Services, 10417 Mt. View Ave., 1st Floor Lunch Room
		2:00 p.m. & 3:30 p.m.	Colton	Arrowhead Regional Medical Center 400 N. Pepper, Oak Room
JUN 7	Mon	9:00 a.m. & 10:30 a.m.	San Bernardino	Public Works, 825 E. 3rd St., Hearing Room
		1:30 p.m. & 3:00 p.m.	San Bernardino	SBPEA, 433 N. Sierra Way
JUN 8	Tue	9:00 a.m. & 10:30 a.m.	San Bernardino	General Services Building, 777 E. Rialto Ave., Large Conference Room
		1:30 p.m	Ontario	JESD, 2314 S. Mountain Ave., Ste. B
		3:30 p.m.	Ontario	TAD, 1627 E. Holt Blvd., Child Care Room
JUN 9	Wed	9:00 a.m., 10:30 a.m. & 1:30 p.m.	San Bernardino	County Government Center 385 N. Arrowhead Ave., Board Chambers
JUN 10	Thu	9:00 a.m. & 10:30 a.m.	Rancho Cucamonga	Child Support Services, 10565 Civic Center Dr., Ste. 250, Lunch Rm.
		1:30 p.m. & 3:00 p.m.	Fontana	TAD, 7977 Sierra Ave., Crosswell Commons Room
JUN 14	Mon	9:00 a.m.	Twin Peaks	County Complex, 26010 State Hwy 189, Conference Room
		11:00 a.m.	Lake Arrowhead	Lake Arrowhead Library 27235 State Hwy 189
		3:00 p.m.	Big Bear	Big Bear Library, 41930 Garstin Dr., Meeting Room
JUN 16	Wed	9:00 a.m. & 10:30 a.m.	Barstow	Public Health, 303 E. Mountain View, Conference Room
		1:30 p.m. & 3:00 p.m.	Barstow	JESD, 1300 E. Mountain View, Job Club Room
JUN 17	Thu	9:00 a.m. & 10:30 a.m.	Needles	Civic Center, 1111 Bailey Ave., Counsel Chambers

2004 Open Enrollment Meeting Schedule *(continued)*

DATE	DAY	TIME	CITY	LOCATION
JUN 21	Mon	9:00 a.m. & 10:30 a.m.	Rancho Cucamonga	Child Support Services, 10565 Civic Center Dr., Ste. 250, Lunch Room
		1:30 p.m. & 3:00 p.m.	Rancho Cucamonga	JESD, 10825 Arrow Rte., 2nd Floor Job Search Room
JUN 22	Tue	9:00 a.m.	Yucaipa	Sheriff's Station, 34282 Yucaipa Blvd., Auditorium
		11:00 a.m., 1:30 p.m. & 3:00 p.m.	Redlands	TAD, 881 W. Redlands Blvd., 2nd Floor, Conference Room A
JUN 23	Wed	9:00 a.m. & 10:30 a.m.	Loma Linda	Child Support Services, 10417 Mt. View Ave., 1st Floor Lunch Room
		2:00 p.m. & 3:30 p.m.	Rancho Cucamonga	West Valley Detention Center, 9500 Etiwanda Ave., Main Conference Room
JUN 24	Thu	9:00 a.m., 10:30 a.m. & 1:30 p.m.	Victorville	Green Tree Inn, 14173 Green Tree Blvd.
JUN 28	Mon	9:00 a.m. & 10:30 a.m.	Yucca Valley	TAD, 56357 Pima Trail, Large Conference Room
		1:00 p.m.	Joshua Tree	Joshua Tree District Court House, 6527 White Feather Rd., Jury Assembly Room
		3:00 p.m.	Twentynine Palms	TAD, 73629 Sun Valley Dr., Conference Room
JUN 29	Tue	9:00 a.m. & 10:30 a.m.	San Bernardino	General Services Building, 777 E. Rialto Ave., Large Conference Room
JUN 30	Wed	9:00 a.m.	Colton	JESD, 850 Via Lata, Suite 100, Room 2
		11:00 a.m.	Colton	TAD, 2040 W. Woodpine Ave., 1st Floor, Conference Room 2
		3:30 p.m.	San Bernardino	TAD, 2050 Massachusetts Ave., Room 2 A&B

2004 Health Fairs

JUN 9	Wed	9:00 a.m. to 3:00 p.m.	San Bernardino	County Government Center, 385 N. Arrowhead Ave., Rotunda
JUN 24	Thu	9:00 a.m. to 3:00 p.m.	Victorville	Green Tree Inn, 14173 Green Tree Blvd.

During Open Enrollment you have an opportunity to enroll or change your coverage. All changes must be completed by June 30.

Eligibility

You must be an employee in a regular position scheduled to work a minimum of 40 hours per pay period, have received pay for at least one half plus one hour of scheduled hours (or be on an approved leave pursuant to the Family Medical Leave Act) and the benefit must be offered to you through a Memorandum of Understanding (MOU), Exempt Compensation Plan, contract or salary ordinance. Safety employees must be scheduled and paid for a minimum 41 hours a pay period. If you are a Safety employee or firefighter, you are not eligible for VUL and AD&D coverage.

Dependent Eligibility

If you are eligible to participate in County-sponsored medical and dental plans, your eligible dependents may also participate. Proof of dependent status for newly enrolled dependents is required.** Your eligible dependents include:

- Your legal spouse
- State Registered Domestic Partner (effective December 25, 2004)
- Your unmarried children* who are:
  - Less than 19 years old
  - 19 years, but less than 24 years, old enrolled in school as a full-time student and supported primarily by you
  - 19 or more years old and supported primarily by you and incapable of self-sustaining employment by reason of mental or physical handicap

* Your children include children born to you, legally adopted by you (including those children during any waiting period before the finalization of their adoption), your stepchildren, your registered Domestic Partner's children, children for whom you are the legal guardian, and children you support as a result of a valid court order. Parents, grandparents, grandchildren, common-law spouses, divorced spouses, roommates, children under age 24 who marry and subsequently divorce, and relatives other than those listed above are not eligible. (Kaiser Permanente allows coverage for grandchildren if the dependent child was enrolled with Kaiser Permanente prior to giving birth to the grandchild. Coverage for the grandchild may continue as long as the dependent child is covered.)

** Photocopies of the following documents may be used to prove dependent status:

- Spouse:
  - Photocopy of marriage certificate (legal or church)
  - Photocopy of 2003 Federal or State Joint Tax Return indicating legal spouse (financial information may be concealed, but signature section is required)
- Domestic Partner:
  - Photocopy of the Certificate of State Registered Domestic Partnership
  - Photocopy of 2003 Federal Tax Return for proof of financial dependency
- Children:
  - Photocopy of birth certificate (legal or hospital)
  - Photocopy of a certificate of baptism (must include date of birth and show employee as parent)
  - Photocopy of court documents for:
    - Adoption
    - Placement
    - Custody
    - Guardianship
    - Other court order stating dependent status
    - Other court order stating benefit coverage must be provided

Enrollment

As a condition of County employment, all employees must be covered by health and dental insurance. If you are an eligible employee, you must enroll in a County-sponsored medical and dental plan unless you have other employer-sponsored group medical and/or dental insurance. If you are an active employee, enrolled in a County-sponsored medical plan, and reach age 65, you will be given the option of remaining on the County-sponsored plan or electing coverage under Medicare Parts A and B. You will be notified of this option just prior to turning 65. Premiums for County-sponsored medical and dental insurance will be deducted from your paycheck.

Opt-Out

If you have other employer-sponsored group medical and/or dental insurance that offers coverage comparable to a County-sponsored plan, you may elect to Opt-Out of the County-sponsored medical and/or dental insurance. To Opt-Out, you must complete the appropriate "Opt-Out Election Agreement" form. If you are Opting-Out during this Open Enrollment for reasons other than initial gain of another employer-sponsored group plan, you must provide proof of other insurance. To continue your Opt-Out election, you must provide verification of continued coverage each year during subsequent Open Enrollment periods.

If you Opt-Out of dental coverage you may not re-enroll in a County-sponsored dental plan for a minimum of two (2) years unless you lose coverage under the other employer-sponsored group dental plan involuntarily.

What Happens If You Don't Enroll Timely?

New Employees — As a new employee, you have thirty (30) days from your date of employment to enroll in a medical and dental plan. The Employee Benefits and Services Division must physically receive your enrollment forms within that 30-day period. If you do not enroll when you are first eligible (or if you submit your enrollment forms late), you will be enrolled automatically in the Health Net Medical Plan and the Delta Care Dental Plan, employee only coverage, and premiums will be deducted after-tax. Dependent coverage and before-tax deductions will not be available to you until the next Open Enrollment.

Open Enrollment — Kaiser Permanente, Blue Cross, Health Net, DeltaPreferred and Delta Care members who do not complete the 2004/2005 Open Enrollment process will maintain their current elections.

Notice

This section is only a Benefit Plan highlight. Your specific rights to benefits under the plan are governed solely and in every respect by the County's Section 125 Premium Conversion Plan Document. A copy of this document is available for your review in the office of the Human Resources Department, Employee Benefits and Services Division.

Medical and Dental Plans ID Cards

Within a month of the effective date of your coverage, you should receive identification (ID) cards from your medical and dental plans. You may, however, begin using your medical and dental plans before receiving your ID cards. If you do not receive your ID cards, or if you need replacement cards, call your plan's member services department. If you have a problem accessing care, call the Employee Benefits and Services Division of Human Resources. *The Contact Information section of this booklet lists the Employee Benefits and Services phone numbers, as well as plan phone numbers and web sites.*

Section 125 Premium Conversion Plan Mid-Year Changes

The enrollment options you elect during the 2004/2005 Open Enrollment period will remain in effect for the entire plan year. You will have to wait until the next Open Enrollment period to make changes UNLESS you experience an IRS "Change in Status Event," such as:

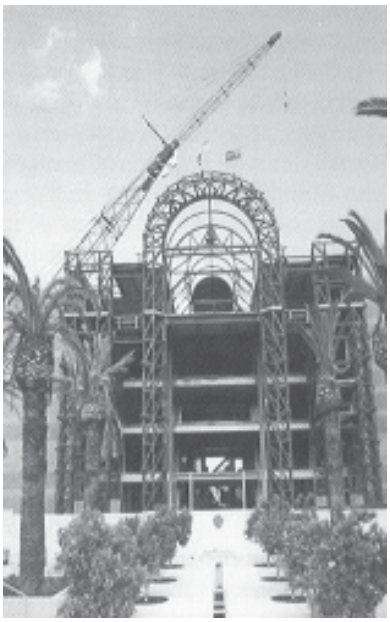
- A legal marital status change including marriage, death of spouse, divorce, legal separation or annulment
- A change in the number of dependents including birth, death, adoption or placement for adoption
- A change in employment status for you, your spouse or your dependent such as termination or commencement of employment, a strike or lockout and commencement or return from an unpaid leave of absence
- Your dependent satisfies or ceases to satisfy eligibility requirements due to age, student status, marital status or any similar circumstance
- A residence change affecting eligibility for you, your spouse or your dependent
- You or your dependent becomes entitled to Medicare or Medicaid (eligibility or loss of eligibility)
- Significant changes in Group Benefit Plan costs or coverage terms including the addition or elimination of a benefit plan
- Commencement of or return from a leave of absence provided through the Family Medical Leave Act
- Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order as defined in Section 609 of the Employee Retirement Income Security Act of 1974) that requires medical or dental coverage for an employee's child or for a foster child who is a dependent of the employee.

If you experience a Change in Status Event and you want to request a mid-year change in your Benefit Plan Premium Conversion Election, you must:

1. Complete the applicable medical, dental, vision, Voluntary Term Life, and/or AD&D enrollment forms (available from your Payroll Clerk);
2. Complete a Benefit Plan Premium Conversion Election/Change form (available from your Payroll Clerk);
3. If the Change in Status Event makes you eligible to Opt-Out of your County-sponsored medical and/or dental plan, complete the appropriate "Opt-Out Election Agreement" form; and
4. Attach documentation that verifies the reason for the mid-year change; examples of acceptable documentation are:

- Copies of birth, death or marriage certificates
- Copies of court papers for divorces, separations or adoptions
- Copy of letter from employer verifying loss or gain of spouse's employment
- Verification of other health and/or dental coverage if Opting-Out

Your request to make a mid-year change must be received by the Employee Benefits and Services Division within 30 days of the qualifying event.



Requests for mid-year changes must be consistent with the Change in Status Event for which you are requesting the change, and must meet the guidelines of County contracts/agreements, plan documents and Internal Revenue Code Section 125.

Effective Date of Mid-Year Changes

All elections made during the plan year shall become effective beginning with the pay period that immediately follows the date that the properly completed Benefit Plan Premium Conversion Election/Change Form is received by the Plan Administrator during the applicable Election Period. Elections shall only apply to compensation that has not yet been earned at the time of the election unless otherwise allowed under IRC Section 125, federal regulations, the County's Section 125 Premium Conversion Plan and the terms of the Group Benefit Plans. Examples: newborns are covered on the date of their birth and children placed for adoption are covered on the date they are placed in the home. You will be billed for any premiums owed as a result of the addition of eligible dependents. If the Change in Status Event results in a decrease in premiums, you will receive a refund on a subsequent pay warrant for the premium overpayment. To reduce the time for a refund or to reduce the amount of premiums owed, you are encouraged to submit your paperwork as soon as possible. If you have questions about mid-year changes, please call the Employee Benefits and Services Division.

Benefit Plan Dollars

To help you pay your medical and dental insurance premiums, the County gives you Benefit Plan Dollars each pay period. To receive Benefit Plan Dollars you must be paid for at least one-half plus one hour of your scheduled hours.

Effective July 10, 2004, the Benefit Plan Dollars per pay period for Regular Employees scheduled to work 40 to 60 hours per pay period is $92.50. For Regular Employees scheduled to work 61 to 80 hours per period, it's $190.00. For Exempt Employees, Benefit Plan Dollars are $115.00 for employees scheduled to work 40 to 60 hours per pay period and $230.00 for employees scheduled to work 61 to 80 hours per pay period.

Section 125 Premium Conversion Plan

Purpose This plan allows employees to pay for eligible benefits using either before-tax or after-tax dollars. If no changes are made during Open Enrollment, the previous elections will continue automatically. For new employees, if no election is made, the deductions will automatically be taken after taxes are calculated and the employee will be subject to all plan requirements and restrictions.

Eligible Before-Tax Premiums

Premiums for the following plans may be deducted from your paycheck before taxes are calculated:

- Medical
- Dental
- Accidental Death & Dismemberment (AD&D)
- Life insurance premiums for coverage up to $50,000; included in this limit is employer-

Warning

Employee Benefits and Services Division must receive your Medical and/or Dental Enrollment/Change Forms within 30 days of a qualified Change in Status Event. If you do not submit the forms and verification within 30 days, you could be denied the opportunity to make plan coverage changes.

You could also lose your before-tax benefit coverage and any possible insurance premium refunds.

paid life insurance coverage. As employer-paid life insurance coverage varies by unit, the amount of the premium for voluntary term life insurance eligible to be paid before taxes will be the difference between the amount of employer-paid life insurance and the amount of voluntary term life insurance. As an example, a member of the Clerical Unit has $20,000 in employer-paid life insurance. This means that the premiums for $30,000 ($50,000 - $20,000 = $30,000) of voluntary term life can be paid before taxes.

Benefit Plan Dollars Table *(Employees working 40-60 Hours)*

Unit	Benefit Dollars	Benefit Dollars for Opt-Out
Administrative Services	$ 92.50	$66.93
Clerical	92.50	66.93
Craft, Labor & Trades	92.50	66.93
Elected Officials	115.00	80.77
Exempt Employees	115.00	80.77
Management	92.50	75.00
Professional	92.50	66.93
Supervisory	92.50	69.24
Technical & Inspection	92.50	66.93

Contract Employees — Varies by contract

Benefit Plan Dollars Table *(Employees working 60-80 Hours)*

Unit	Benefit Dollars	Benefit Dollars for Opt-Out
Administrative Services	$190.00	$133.85
Clerical	190.00	133.85
Craft, Labor & Trades	190.00	133.85
Elected Officials	230.00	161.54
Exempt Employees	230.00	161.54
Management	190.00	150.00
Professional	190.00	133.85
Safety	138.46	138.46
Safety Management & Supervisory	150.93	150.93
Supervisory	190.00	138.46
Technical & Inspection	190.00	133.85

Contract Employees — Varies by contract

Section 125 Premium Conversion Plan Election You must notify the County of your choice to deduct eligible insurance premiums from your paycheck either before or after taxes are calculated. The four plans for which you must decide are 1) Medical, 2) Dental, 3) Voluntary Term Life, and 4) Accidental Death and Dismemberment (AD&D). Variable Universal Life is not eligible for before-tax deduction. Plan elections are irrevocable for the plan year unless you have an IRS Change in Status Event.

Before-Tax Option This option is especially attractive as it results in greater take-home pay. It does, however, limit your mid-year changes (involving premium increases or decreases) to the Change in Status Events as specified in Internal Revenue Code Section 125 and the County's Section 125 Premium Conversion Plan.

You are encouraged to review the list in the Mid-Year Changes section carefully. If you anticipate only the mid-year changes included on this list, you might want to choose before-tax premium deductions for tax savings all year.

After-Tax Option This option results in less take home pay. However, it allows you to make enrollment changes for reasons that are not considered IRS qualified Change in Status Events. Changes are still limited to those allowed by the County's contracts, agreements or plan documents governing the benefits.

Again, you are encouraged to review the list in the Mid-Year Changes section carefully. If you anticipate a mid-year change not included on this list, you might want to choose after-tax premium deductions for the plans that would be affected by the mid-year change.

Election of Before-Tax Benefits

Open Enrollment: To have your medical and dental premiums deducted from your pay before federal and state taxes are withdrawn, you must use eBenefits to select the appropriate before-tax plan.

Mid-Year Change: To have your medical and dental premiums deducted from your pay before federal and state taxes are withdrawn, you must submit a completed Benefit Plan Premium Conversion Election form. If you do not submit the form on a timely basis, all eligible insurance premiums will be deducted on an after-tax basis.

Plan Termination The plan terminates on the date you cease to be an eligible participant (e.g., termination or reduction in hours).

Health and Welfare Plans Highlights

As you review the comparison charts and plan highlights on the following pages, keep these important questions in mind:

- What are my current benefits needs?
- Are these needs different than they were in the past?
- Do I anticipate new or different needs for the coming year?
- How do these needs affect my current benefits elections and the choices I need to make?

Medical Plans Comparison Chart

	HEALTH NET ELECT OPEN ACCESSS		KAISER PERMANENTE HMO
	Tier One	Tier Two	
Allergy testing	You pay a $10 copay (serum covered)	You pay a $30 copay (serum covered)	No charge
Ambulance	No charge when medically necessary	Not covered	No charge when medically necessary
Ambulatory surgical center	No charge	Not covered	$10 copay per procedure
Choice of physician and other providers	Health Net HMO provider network	Health Net PPO physicians only	Kaiser physicians and facilities only
Deductibles Calendar year	None	None	None
Hospital or ambulatory surgical center deductible	None	None	None
Non-certification deductible	None	PPO services that require certification are not covered	None
Diagnostic X-rays and lab tests	No charge	Covered only when performed in physician's office	No charge
Durable medical equipment	No charge	Not covered	No charge
Emergency room Outpatient hospital services	You pay a $50 copay (waived if admitted)	Not covered	You pay a $50 copay (waived if admitted)
Family planning Infertility services	You pay 50%; excludes GIFT, ZIFT and IVF	Not covered	You pay 50%; excludes GIFT, ZIFT and IVF
Tubal ligation	You pay a $10 copay	Not covered	You pay a $10 copay
Vasectomy	You pay a $10 copay	Not covered	You pay a $10 copay
Home health services	No charge when medically necessary	Not covered	No charge when medically necessary
Hospice Inpatient & outpatient	No charge when medically necessary	Not covered	No charge when selected as alternative to traditional services covered by Kaiser Permanente
Hospital care	No charge	Not covered	No charge for approved services obtained in a Kaiser Permanente facility/approved facility
Lifetime benefits maximum	No limit	No limit	No limit
Maternity care	No charge except $10 for first prenatal and postnatal visit	Not covered	$10 for first outpatient visit, no charge thereafter

	BLUE CROSS PPO In-Network	Out-of-Network
Allergy testing	You pay 20% after deductible	You pay 30% after deductible
Ambulance	You pay 20% after deductible when medically necessary	You pay 30% after deductible when medically necessary
Ambulatory surgical center	You pay 20% after deductible at network facilities	You pay 30% after deductible
Choice of physician and other providers	Any Prudent Buyer network physician and/or facility	You may self-refer to any licensed providers; but you pay 30% after deductible plus any costs over the Usual, Customary and Reasonable amount
Deductibles Calendar year	$250 each covered member $750 family maximum	$250 each covered member $750 family maximum
Hospital or ambulatory surgical center deductible	$250 each covered member, $750 family maximum (per calendar year, not plan year)	$250 each covered member $750 family maximum
Non-certification deductible	$250 unless pre-authorization is not obtained	$250 for each admission if Prudent Buyer pre-authorization is not obtained (waived for emergency admission)
Diagnostic X-rays and lab tests	You pay 20% after deductible	You pay 30% after deductible
Durable medical equipment	You pay 20% after deductible; up to $5,000 per calendar year	You pay 30% after deductible; up to $5,000 per calendar year
Emergency room Outpatient hospital services	You pay a $50 copay (waived if admitted)	You pay a $50 copay (waived if admitted)
Family planning Infertility services	Not covered	Not covered
Tubal ligation	You pay 50% after deductible (coinsurance does not apply to Out-of-Pocket maximum)	You pay 50% after deductible (coinsurance does not apply to Out-of-Pocket maximum)
Vasectomy	You pay 50% after deductible (coinsurance does not apply to Out-of-Pocket maximum)	You pay 50% after deductible (coinsurance does not apply to Out-of-Pocket maximum)
Home health services	You pay 20% after deductible; 100 visits per year maximum	You pay 30% after deductible; 100 visits per year maximum
Hospice Inpatient & outpatient	You pay 20% after deductible; $10,000 lifetime benefit	You pay 30% after deductible; $10,000 lifetime benefit
Hospital care	You pay 20% after deductible	You pay 30% after deductible
Lifetime benefits maximum	$2,000,000	$2,000,000
Maternity care	You pay 20% after deductible	You pay 30% for outpatient visits; you pay 30% after deductible for hospital care

continued	HEALTH NET ELECT OPEN ACCESS Tier One	 Tier Two	KAISER PERMANENTE HMO
Mental health services	Upgraded MHN Network		
Other mental disorders	Inpatient: No charge; up to 30 visits per year Outpatient: You pay $20; up to 20 visits per year	Inpatient: Not covered Outpatient: Not covered	Inpatient: No charge; up to 30 days per calendar year Outpatient: You pay a $10 copay; up to 20 visits per calendar year
Severe mental disorders	Inpatient: No charge; unlimited days Outpatient: You pay $10; unlimited visits	Inpatient: Not covered Outpatient: Not covered	Inpatient: No charge; unlimited days Outpatient: You pay a $10 copay; unlimited visits
Out-of-Pocket annual maximum	$1,500 each member $3,000 family maximum	$1,500 each member $3,000 family maximum	$1,500 each member $3,000 family maximum
Physician services: Home visits	You pay a $10 copay	Not covered	No charge; only when medically necessary
Hearing screenings	You pay a $10 copay	You pay a $30 copay	You pay a $10 copay
Hospital services	No charge	Not covered	No charge
Immunizations (includes allergy injections, etc.)	You pay a $10 copay	You pay a $30 copay	No charge
Office visits	You pay a $10 copay	You pay a $30 copay	You pay a $10 copay
Routine physicals	You pay a $10 copay; maximum 1 per year	Not covered	You pay a $10 copay
Specialists	You pay a $10 copay	You pay a $30 copay	You pay a $10 copay
Surgical services	No charge	Physician's office only	No charge
Well baby Well child care	You pay a $10 copay	You pay a $30 copay	No charge
Well woman exam (annual)	You pay a $10 copay (no limit)	You pay a $30 copay	You pay a $10 copay
Physical and occupational therapy, Chiropractic Care	You pay a $10 copay Chiropractic Care is not covered	You pay a $30 copay; up to 12 visits. Chiropractic Care is not covered	You pay a $10 copay; up to 60 visits per calendar year Chiropractic Care is not covered
Pre-existing condition	Fully covered	Fully covered	Fully covered
Prescription drugs (per fill)	Pharmacy (30-day supply) / Mail order (90-day supply) $5 generic $10 $10 brand name $20 $25 non-formulary $50	Pharmacy (30-day supply) / Mail order (90-day supply) $5 generic $10 $10 brand name $20 $25 non-formulary $50	Pharmacy Generic $10 copay Brand Name $15 copay Sexual Dysfunction and Infertility 50% Coinsurance
Skilled nursing facilities	No charge	Not covered	No charge for authorized stays; maximum 100 days per benefit period at a contracting skilled nursing facility
Speech therapy	You pay a $10 copay	You pay a $30 copay; up to 12 visits	You pay a $10 copay per visit; up to 60 days per calendar year as medically necessary
Substance abuse **Rehab:**	Inpatient: No charge; up to 30 days per year Outpatient: You pay $20; up to 20 visits per year	Inpatient: Not covered Outpatient: Not covered	Inpatient: $100 per admission; up to 60 days per calendar year Outpatient: $10 copay individual, $5 copay group
Detox:	Inpatient: No charge; up to 3 days Outpatient: Not covered	Inpatient: Not covered Outpatient: Not covered	Inpatient: No charge Outpatient: $10 copay individual, $5 copay group
Urgent care	You pay a $25 copay	Not covered	You pay a $10 copay
Vision (Exam only)	You pay a $10 copay	You pay a $30 copay	You pay a $10 copay

continued	BLUE CROSS PPO In-Network	Out-of-Network
Mental health services (Combined with substance abuse)	Inpatient: You pay 20% after deductible; up to 30 days per calendar year. (Does not apply to Out-of-Pocket maximum.) Outpatient: You pay everything over $20 per visit; up to 50 visits per calendar year. (Does not apply to Out-of-Pocket maximum.)	Inpatient: You pay 30% after deductible Outpatient: You pay 30% after deductible
Out-of-Pocket annual maximum	$1,500 each member No family maximum (excludes family planning, prescription drugs, outpatient mental health, outpatient substance abuse, and psychotherapy/psychology testing)	$2,000 each member No family maximum (excludes family planning, prescription drugs, outpatient mental health, outpatient substance abuse, and psychotherapy/psychology testing)
Physician services: Home visits	You pay 20% after deductible	You pay 30% after deductible
Hearing screenings	You pay 20% after deductible	You pay 30% after deductible
Hospital services	You pay 20% after deductible	You pay 30% after deductible
Immunizations (includes allergy injections, etc.)	You pay 20% after deductible	You pay 30% after deductible
Office visits	You pay 20% after deductible	You pay 30% after deductible
Routine physicals	You pay 20% after deductible	You pay 30% after deductible
Specialists	You pay 20% after deductible	You pay 30% after deductible
Surgical services	You pay 20% after deductible	You pay 30% after deductible
Well baby Well child care	You pay 20% after deductible	You pay 30% after deductible plus any costs over $20
Well woman exam (annual)	You pay 20% after deductible	You pay 30% after deductible
Physical and occupational therapy, Chiropractic Care	You pay 20% after deductible; up to 30 visits per calendar year	You pay 30% after deductible, plus any costs over $25 per visit; up to 30 visits per calendar year
Pre-existing condition	Fully covered	Fully covered
Prescription drugs (per fill)	Pharmacy Mail order $15 generic $30 50% coinsurance for lifestyle drugs Brand name only covered if generic is unavailable. (Does not apply to Out-of-Pocket maximum.)	Pharmacy Mail order $15 generic $30 50% coinsurance for lifestyle drugs Brand name only covered if generic is unavailable. (Does not apply to Out-of-Pocket maximum.)
Skilled nursing facilities	You pay 20% after deductible; 100 days per calendar year at a contracting skilled nursing facility	You pay 30% after deductible; 100 days per calendar year at a contracting skilled nursing facility
Speech therapy	You pay 20% after deductible; up to 24 visits per calendar year; when due to surgery, injury or organic disease	You pay 30% after deductible; up to 24 visits per calendar year; when due to surgery, injury or organic disease
Substance abuse (Combined with mental health services)	Inpatient: You pay 20% after deductible; up to 30 days per calendar year. (Does not apply to Out-of-Pocket maximum.) Outpatient: You pay anything over $20 per visit; up to 50 visits. (Does not apply to Out-of-Pocket maximum.)	Inpatient: You pay 30% after deductible Outpatient: You pay 30% after deductible
Urgent care	You pay 20% after deductible	You pay 30% after deductible, plus anything over UCR
Vision (Exam only)	You pay 20% after deductible	Not covered

Health Net ELECT Open Access

(This is a general summary of Health Net benefits. A more complete description of benefits and the terms under which they are provided, including limitations and exclusions, are contained in the plan documents. If there are any discrepancies between the information contained in this summary and the provisions of the plan documents, the plan documents are the controlling documents.)

Health Net ELECT Open Access is a Health Maintenance Organization (HMO) plan with a Point-of-Service (POS) provision. The HMO provision requires that you select a Primary Care Physician (PCP) from one of the Health Net Participating Physician Groups. The POS component gives you the option of seeking consultations and evaluations from any specialist within the Health Net network without a referral from your PCP. The HMO provision is referred to as TIER 1 and the POS provision as TIER 2.

Under TIER 1 (the HMO), you receive all of your care from within your PCP's network of participating physicians, hospitals, and other health care providers. Under TIER 2 (the POS option), you are allowed consultations with a doctor outside of your Participating Physician Group, but within Health Net's Preferred Provider Organization (PPO) network, without a referral from your PCP.

How the Plan Works

With Health Net, you must choose a PCP from a Health Net Participating Physician Group when you enroll. If you also enroll dependents, each dependent can choose their own Participating Physician Group and PCP. You may not choose a specialist as a PCP. Your PCP will treat you for many medical conditions, perform preventive care services and coordinate all of your health care, including making referrals to specialists and hospitals within your Participating Physician Group. Also, under the HMO (TIER 1) component, you are allowed to self-refer for one annual OB/GYN appointment. You must select an OB/GYN provider who is in the same Participating Physician Group as your PCP for the visit to be covered at the HMO benefit level. Using your PCP and using the HMO option is the most cost effective, lowest out-of-pocket cost way to use the plan.

However, with the TIER 2 (Open Access) component, you may see any doctor or specialist in the Health Net Preferred Provider Organization network without a referral from your PCP. When you use this option, your costs will be higher and you may have to file claim forms for certain services. This direct access feature only covers office visits, consultation, evaluation and treatment -- procedures that can be performed in the doctor's office. Some services may require certification from Health Net. Services requiring hospitalization, outpatient surgery, maternity care and other therapeutic care must be coordinated and authorized by your PCP under the TIER 1 option.

If you need a Health Net HMO or PPO Provider Directory, please call Health Net's Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish), or use Health Net's web site at www.healthnet.com. The directory lists physicians and medical groups accepting new patients. If your current physician or medical group accepts Health Net but is not listed in the Directory, call Health Net's Member Services for assistance. Once enrolled in Health Net, you can also call Member Services to change your PCP.

Copayments For most routine HMO care, you pay a $10 copayment. For other services, copayments range from $10 to 50% of actual charges. For TIER 2, copayments for covered benefits are normally $30.

Deductible Under Health Net, you pay no deductibles.

Hospitalization You are covered for all medically necessary hospitalization when admitted by your PCP.

Emergency Care If you need emergency services, you should call 911 or go directly to the nearest medical facility for treatment. Emergency Care is any otherwise covered service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, the health of her unborn child)
- His or her bodily functions, organs or parts would become seriously damaged
- His or her bodily organs or parts would seriously malfunction

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the "911" emergency response system. Emergency Care also includes treatment of severe pain or active labor. Health Net will make any final decisions about Emergency Care.

If you seek Emergency Care, please inform Health Net of the locations, duration and nature of the services provided.

Out-of-Area Care If you need urgent medical care and cannot get to your PCP, call your PCP for guidance. If you are unable to contact your PCP, you should seek care for Urgently Needed Services from a licensed medical professional where you are located and notify your Participating Physician Group as soon as possible afterwards.

Claim Forms Under the Health Net HMO component you do not have to file claim forms. You may have to file claim forms when using your TIER 2 benefits or following Emergency Care or out-of-area Urgent Care services.

Medical Transition of Care Benefit

As a new member you are entitled to a medical review that may allow you to continue your current treatment plan due to a specific diagnosis for a specified time frame with your prior provider.

Some examples of circumstances for you or a member of your family:

- You are in the second or third trimester of pregnancy or a high-risk pregnancy and are currently established with an Obstetrician.
- You are scheduled for surgery within 3 weeks after your effective date of coverage.
- You have documented follow-up care for surgery that was completed within 6 weeks prior to your effective date of coverage.
- You have complications resulting from surgery performed within the month prior to your effective date of coverage.
- You are presently undergoing a course of chemotherapy or radiation therapy.
- You are approved for or on a waiting list for a transplant.
- You have an acute or serious chronic condition.
- You are currently receiving outpatient mental health treatment or you are currently in a chemical dependency treatment program.

If you have a transition of care issue, please complete a Health Net Transition of Care Assistance Request Form. You can get a copy of the form from your Payroll Clerk, the Employee Benefits and Services Division or by calling Health Net Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish).

Call Health Net's Member Services if you

- Need to choose a PCP
- Have a benefits question
- Need hospital certification
- Need a Provider Directory
- Need a member identification (ID) card
- Have an eligibility question

The exclusions and limitations listed, beginning on this page, represent the services and supplies that are not covered expenses under the Health Net Plan.

How to Enroll

New employees must enroll within 30 days of hire into an eligible position. Remember, proof of dependent status is required for each dependent you enroll on the plan.

What's Covered

While covered under Health Net, you can take advantage of comprehensive medical benefits. Please refer to the Medical Plans Comparison Chart on pages 14 through 17 of this Guide for a summary of covered expenses. Remember, this Guide only provides a summary of the benefits available through Health Net. The Health Net contract determines the exact terms and conditions of coverage.

What's Not Covered

Services and benefits for care and conditions as described below are a summary of what shall be excluded from coverage under this plan unless specifically included as a supplemental benefit. Exclusions and Limitations are subject to change, please refer to the current Health Net Evidence of Coverage (EOC) or contact Health Net's Member Services at 1-800-676-6976 or 1-800-331-1777 (Spanish) for additional information.

General Exclusions

It is extremely important to read your EOC before you obtain services in order to know what Health Net will and will not cover. Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the EOC, appear in the EOC as "Not Covered," exceed EOC limitations, are not Medically Necessary, or are follow-up care to EOC exclusions or limitations will not be covered.

TIER 1 (HMO)

Blood Blood transfusions, including blood processing, the cost of blood, unreplaced blood, and blood products, are covered. However, self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group has authorized and scheduled.

Chemical Dependency This Plan does not cover treatment of chronic alcoholism, drug addiction, or other Chemical Dependency problems, except as specified in the portion of the "Covered Services and Supplies" section of this EOC.

Clinical Trials Although clinical trials are covered, as described in the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section of this EOC, coverage for clinical trials does not include the following items:

- Drugs or devices that are not approved by the FDA;
- Services other than health care services including, but not limited to, cost of travel or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this Evidence of Coverage; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Conception by Medical Procedures Artificial insemination is covered when a female Member and/or her male partner is infertile (refer to Infertility in the “Definitions” section of this *Evidence of Coverage*). If the male partner is the Member and the female partner is infertile, artificial insemination will not be covered. The collection, storage or purchase of sperm is not covered.

Other services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting, or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage, or purchase of sperm or ova.

Contraceptives Vaginal contraceptives are covered as a Prescription Drug benefit and are limited to diaphragms and cervical caps, and

are only covered when a Member Physician performs a fitting examination and prescribes the device. Such devices are covered up to the number of fittings and prescriptions stated in the "Prescription Drugs" portion of this section. Injectable contraceptives are covered as a medical benefit when administered by a Physician. Oral contraceptives are covered, as described in the "Prescription Drugs" portion of the "Covered Services and Supplies" section of this section. Norplant and Norplant kits are not covered, except when Medically Necessary.

Cosmetic Services and Supplies Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Member are not covered. In addition, hair transplantation, hair analysis, hairpieces and wigs, chemical face peels, abrasive procedures of the skin, liposuction, or epilation are not covered.

However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, and such surgery does either of the following:

- Improve function; or
- Create a normal appearance to the extent possible;

Then

- Surgery to remove or change the size (or appearance) of any part of the body; or
- Surgery to remove or reduce skin or tissue

are covered.

In addition, when a Medically Necessary mastectomy has been performed, the following are covered:

- Breast reconstruction surgery, and
- Surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breast.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that the length of Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and no prior authorization for determining length of stay is required.

Custodial or Domiciliary Care The Plan does not cover services and supplies that are provided primarily to assist with the activities of daily living, regardless of where performed.

Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a physician assistant or physical therapist.

Dental Services Dental services or supplies are limited to the following situations.

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to the "Emergency and Urgently Needed Care Through Your ELECT Open Access Plan" portion of the "Introduction to Health Net," in the EOC for more information.
- When the clinical status or underlying medical condition of the member requires that an ordinary non-covered dental service which would normally be treated in a dentist's office without general anesthesia must instead be treated in a Hospital or an Outpatient Surgical Center. Such services, including general anesthesia and associated facility services, must be medically necessary and subject to the other exclusions and limitations of the EOC and will be covered for Members under any of the following circumstances:
  (a) members who are under seven (7) years old,
  (b) developmentally disabled, or
  (c) whose health is compromised and general anesthesia is medically necessary.
- When Dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.

The following services are not covered under any circumstances including those listed above.

- Routine care or treatment of teeth and gums including, but not limited to, dental abscesses, inflamed tissue or extraction of teeth.

◆ Spot grinding, restorative or mechanical devices, orthodontics, crowns, bridgework, dental implants and related surgeries.
◆ Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury.

Disorders of the Jaw Treatment for disorders of the jaw is limited to the following situations:
◆ Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered if the services are required due to recent injury, the existence of cysts, tumors, or neoplasms, or a functional disorder, and they are Medically Necessary.
◆ Surgical procedures and medical appliances to correct disorders of the temporomandibular (jaw) joint (also known as TMJ disorders) are covered if they are Medically Necessary. However, crowns, inlays, onlays, bridgework, splints or other dental appliances (including, but not limited to, orthotics, whether or not custom fit, to treat dental conditions related to TMJ disorders) are not covered.

TMJ disorders are generally caused when the chewing muscles and jaw joint do not work together correctly, and may cause headaches, tenderness in the jaw muscles, or facial pain.

Disposable Supplies for Home Use This Plan does not cover disposable supplies for home use.

Durable Medical Equipment Although this Plan covers Durable Medical Equipment, it does not cover the following items:
◆ Exercise equipment.
◆ Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
◆ Stockings, corrective shoes, and arch supports.
◆ Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
◆ Jacuzzis and whirlpools.
◆ Orthotics, unless custom made to fit the Member's body. (Orthotics are supports or braces for weak or ineffective joints or muscles.)
◆ Orthotics, whether or not custom fit, to treat dental conditions related to TMJ disorder.
◆ Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace, or strapping of the foot, unless the Group purchases a specific benefit for foot orthotics.

Experimental or Investigational Services Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:
◆ Independent review deems them appropriate. Please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section of the EOC for more information; or
◆ Clinical trials for cancer patients are deemed appropriate according to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" section of the EOC.

In addition, benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.

Genetic Testing and Diagnostic Procedures Coverage is limited to prenatal diagnosis of fetal genetic disorders in cases of high-risk pregnancy, as determined by Health Net and the Member's Physician. Other diagnostic procedures or testing for genetic disorders are not covered.

Hearing Aids The Plan does not cover any device inserted in or affixed to the outer ear to improve hearing.

Home Births A birth which takes place at home will be covered when the criteria for Emergency Care, as defined in the EOC, have been met.

Home Visit Visits by a Physician to a Member's home are not covered even if the Physician concludes that the visit is medically and otherwise reasonably indicated unless otherwise noted.

Ineligible Status The Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after coverage through this Plan has ended are not covered, except as specified in the "Extension of Benefits" portion of "Eligibility, Enrollment and Termination" of the EOC.

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

Mental Disorders This ELECT Open Access Plan does not cover treatment of Mental Disorders except as specifically described in the "Schedule of Benefits and Copayments" section of the EOC. This Plan does not cover care for mental retardation, mental health care as a condition of parole or probation, or court-ordered testing for Mental Disorders.

Services and supplies for treating Mental Disorders are covered only as specified in the "Mental Disorders Benefits" portion of the "Covered Services and Supplies" section of the EOC.

No-Charge Items The ELECT Open Access Plan does not cover services or supplies for which you are not legally required to pay or for which no charge is made.

Noneligible Institutions This Plan only covers services or supplies provided by a legally operated Hospital, Medicare-approved Skilled Nursing Facility, or other properly licensed facility specified as covered in the EOC. Any institution that is primarily a place for the aged, a nursing home, or a similar institution, regardless of how it is designated, is not an eligible institution. Services and supplies that are provided by such institutions are not covered.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies Medical equipment and supplies (including insulin) that are available without a prescription are covered when prescribed by a Physician for the management and treatment of diabetes. Any other nonprescription drug, medical equipment or supply that can be purchased without a Prescription Drug Order is not covered, even if a Physician writes a Prescription Drug Order for such drug, equipment or supply.

Personal or Comfort Items This Plan does not cover personal or comfort items.

Physician Self-Treatment This Plan does not cover Physician self-treatment rendered in a nonemergency. Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Physicians Treating Immediate Family Members This Plan does not cover routine or ongoing treatment or consultation provided by the Member's parent, spouse, child or sibling. Members who receive routine or ongoing care from a member of their immediate family may be reassigned to another Physician.

Prescribed Drugs and Medications This Plan only covers outpatient Prescription Drugs or medications, as described in the "Prescription Drugs" portion of the "Covered Services and Supplies" section of the EOC.

Private Duty Nursing This Plan does not cover private duty nursing for registered bed patients in a Hospital or long-term care facility.

Refractive Eye Surgery This Plan does not cover eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), or astigmatism.

Rehabilitation Therapy This Plan does not cover rehabilitation therapy services (physical, speech and occupational therapy) provided in connection with the treatment of the following conditions:

- Psychosocial speech delay (includes delayed language development)
- Mental retardation or dyslexia
- Attention deficit disorders and associated behavior problems
- Developmental articulation and language disorders
- Pervasive developmental disorder or autism

However, some of the above conditions shall be covered when Medically Necessary as shown in the "Schedule of Benefits and Copayments - ELECT 1" of the EOC, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness" and continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

Reversal of Surgical Sterilization This Plan does not cover services to reverse voluntary, surgically induced sterility.

Routine Physical Examinations This Plan does not cover routine physical examinations for insurance, licensing, employment, school, camp, or other non-preventive purposes.

Sex Change This Plan does not cover procedures or treatment related to changing a Member's physical characteristics to those of the opposite sex.

Surrogate Pregnancy This Plan does not cover services for a surrogate pregnancy when compensation is obtained for the surrogacy. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person.

Treatment of Obesity Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity as determined by Health Net.

Unauthorized Services and Supplies This Plan only covers medical services or supplies that are authorized according to procedures Health Net and the contracting Physician Group have established.

Unlisted Services This Plan only covers services or supplies that are specified as covered services or supplies in the EOC, unless coverage is required by state or federal law.

Vision Therapy, Eyeglasses and Contact Lenses This Plan does not cover vision therapy, eyeglasses or contact lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

TIER 2

In addition to the TIER 1 Services and Supplies exclusions and limitations, the following Services and Supplies are not covered through your TIER 2 benefits. The exclusions and limitations from the "TIER 1 Services and Supplies" section above apply to TIER 2.

Ambulance Any services or supplies related to ground or air ambulance or other medical transportation services.

Durable Medical Equipment Any services or supplies related to durable medical equipment are only covered through TIER 1.

Family Planning Any expenses for Infertility, for both male and female, are not covered including professional services, inpatient and outpatient care, treatment by injection and Prescription Drugs.

Home Health Care Visits Any services or supplies related to services provided by a Home Health Care Agency.

Hospice Care Any services or supplies provided by a Hospice.

Immunizations or Inoculations For adults or children, except as provided under the preventive care services.

Infertility Services and Supplies All services or supplies, including injections, related to the treatment of Infertility.

Inpatient Care Any expense related to inpatient Hospital or skilled nursing care are not covered.

Mental Disorders and Chemical Dependency The exclusions and limitations in the "Services and Supplies" portion of this section apply to Mental Disorders and Chemical Dependency.

Note: Services or supplies excluded under the Mental Disorders and Chemical Dependency benefits may be covered under your medical benefits portion of the EOC. Please refer to the “Medical Services and Supplies” portion of “Covered Services and Supplies” section, for more information.

Mental health care as a condition of parole or probation, or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan’s day or visit limits as shown in the “Schedule of Benefits and Copayments” section of the EOC.

Additional exclusions and limitations:

The following exclusions apply specifically to Mental Disorders and Chemical Dependency.

◆ Aversion Therapy Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.

◆ Congenital and Organic Disorders Treatment of physiological diseases or defects including, but not limited to, organic brain disease and mental retardation is not covered. However, some conditions shall be covered as shown in the "Schedule of Benefits and Copayments" section provided that their level of severity meets the criteria described in the

definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness" of the EOC.

◆ Detoxification in Newborns Treatment of detoxification in newborns is not covered.

◆ Educational and Employment Services Services related to educational and professional purposes are not covered, including:

- Vocational rehabilitation.
- Employment counseling, training or educational therapy for learning disabilities.
- Investigations required for employment.
- Education for obtaining or maintaining employment, or for professional certification.
- Education for personal or professional growth, development, or training.
- Academic education during residential treatment.

◆ Excess Services Services in excess of those authorized by the Behavioral Health Administrator's Medical Director or his/her designee.

◆ For Insurance Services for obtaining or maintaining insurance are not covered.

◆ Learning Disabilities Testing, screening or treatment for learning disabilities are not covered. However, some conditions shall be covered as shown in the "Schedule of Benefits and Copayments" section of the EOC, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" and "Severe Mental Illness" and the conditions are treated by Participating Mental Health Professionals.

◆ Nonabstinence-Based Treatment Chemical Dependency treatment not based on abstinence is not covered.

◆ Noncontracting Providers or Facilities Services, treatment or supplies rendered in a non-emergency by a non-participating provider or non-participating facility are only covered when authorized by the Behavioral Health Administrator's Medical Director or his/her designee or otherwise provided by the Plan. For information on “Continuity of Care” through a non-Participating Mental Health Professional, please see the “Mental Disorders and Chemical Dependency (TIER 1)” portion of the “Covered Services and Supplies” section of the EOC.

This includes, but is not limited to, those cases where the Behavioral Health Administrator refers a member to a noncontracting provider or authorizes Emergency or Urgently Needed Care or a second opinion.

◆ Noncovered Treatments The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

- Treatment ordered by a court of law.
- Treatment of chronic pain.
- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or family dysfunction.

Treatment for smoking cessation, weight reduction, obesity, stammering, stuttering, or sexual addiction is not covered. Treatment related to judicial or administrative proceedings that is not Medically Necessary is also not covered.

Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation other than Medically Necessary services for accompanying behavioral and/or psychological symptoms if amenable to psychotherapeutic or psychiatric treatment, is not covered.

In addition, treatment by providers other than those within licensing categories then recognized by the Behavioral Health Administrator as providing Covered Services in accordance with applicable medical community standards is not covered.

◆ Nonstandard Therapies Services that do not meet national standards for professional mental health practice including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, applied behavioral analysis and crystal healing therapy are not covered.

◆ Nontreatable Disorders Mental Disorders or conditions of Chemical Dependency that the Behavioral Health Administrator determines are not likely to improve with generally accepted methods of treatment are not covered.

◆ Private Duty Nursing Private duty nursing services in the home or in a Hospital are not covered.

◆ Psychological Testing Psychological testing is only covered when ordered by a licensed Participating Mental Health Professional and is Medically Necessary to diagnose a Mental Disorder for purposes of developing a mental health treatment plan

when Medically Necessary to treat a Mental Disorder or condition of Chemical Dependency.

◆ State Hospital Treatment Services in a state Hospital are limited to treatment or confinement as the result of an emergency or Urgently Needed Care as defined in the "Definitions" section of the EOC.

◆ Telephone Consultations Treatment or consultations provided by telephone are not covered.

◆ Treatment by a Relative Treatment or consultation provided by the Member's parents, siblings, children, current or former spouse, or any adults who live in the Member's household is not covered.

Organ, Tissue and Bone Marrow Transplants Any expense related to the replacement of any body organ, tissue or bone marrow, whether Experimental or not, are not covered.

Outpatient Hospital Services Any expense, including outpatient surgery, is not covered.

Patient Education Wellness and other educational programs are not covered.

Pregnancy All services and supplies related to pregnancy. In addition, any services related to pregnancy induced under a surrogate parenting agreement are not covered.

Preventive Care Preventive care and diagnostic procedures for adults (18 and older), at the Physician's direction, are limited to the following types of care and procedures:

– Mammography For screening purposes in women at low risk of breast cancer. One baseline low dose mammogram between the ages of thirty-five (35) and thirty-nine (39), one baseline low dose mammogram every two Calendar Years between the ages of forty (40) and forty-nine (49), and one baseline low dose mammogram every Calendar Year when age fifty (50) and above.

– Cervical Cancer Screening Test, Pelvic Exam and Breast Exam One normal exam and lab test per Calendar Year.

– Sigmoidscopy Once every three Calendar Years for men and women age forty-five (45) and above.

– Screening and Diagnosis of Prostate Cancer Tests and procedures for the screening and diagnosis of prostate cancer including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when Medically Necessary and consistent with good professional practice. However, radical prostatectomy, external beam radiation therapy, radiation seed implants, and combined hormonal therapy are specifically excluded.

Services which exceed the above limitations are not covered.

Prescription Drugs The exclusions and limitations in the "Services and Supplies" portion of this section apply to Prescription Drugs.

Note: Services or supplies excluded under the Prescription Drug benefits may be covered under your medical benefits portion of the EOC. Please refer to the "Medical Services and Supplies" portion of the "Covered Services and Supplies" for more information.

Additional exclusions and limitations:

◆ Allergy Serum Products to lessen or end allergic reactions are not covered.

◆ Appetite Suppressants or Drugs for Body Weight Reduction Drugs that are appetite suppressants or are indicated for and prescribed for body weight reduction are not covered except when prescribed for the treatment of morbid obesity, and Prior Authorization is obtained from Health Net.

◆ Blood Biological sera, blood, blood derivatives, and blood plasma are not covered.

◆ Compounded Drugs Prescription orders that are combined or manufactured by the pharmacist and placed in an ointment, capsule, tablet, solution, suppository, cream or other form using FDA approved drugs, are covered at the Level III Drug Copayment only when the primary drug used is on the Health Net Recommended Drug List and the prescription is being used for a FDA approved indication. Compounded drugs are not covered when the primary drug used is a non-FDA approved drug. They are also not covered if there is a similar proprietary product available.

◆ Contraceptives Oral contraceptives and emergency contraceptives are covered, as described in the "Prescription Drugs" portion of the "Covered Services and Supplies" section of the EOC. Norplant and Norplant kits are not covered, except when Medically Necessary. Vaginal contraceptives are limited to diaphragms and cervical caps and are only covered when a Member Physician performs a fitting examination and prescribes the device

(limited to one fitting and prescription per Calendar Year). Injectable contraceptives are covered as a medical benefit when administered by a Physician.

◆ Contraceptive Foams, Abortifacients, Menstrual Induction Drugs Contraceptive foams or abortifacients or menstrual induction drugs are not covered.

◆ Devices Coverage is limited to vaginal contraceptive devices. No other devices are covered even if prescribed by a Member Physician.

◆ Dietary or Nutritional Supplements Drugs used as dietary or nutritional supplements, including vitamins and herbal remedies, are limited to drugs that are listed in the Recommended Drug List.

◆ Drugs Covered by Another Section Prescription Drugs covered in whole or in part elsewhere in this Plan are not covered by this benefit.

◆ Drugs Prescribed for Cosmetic Purposes Drugs that are prescribed to enhance or maintain appearance including, but not limited to, those intended to treat wrinkles or hair loss are not covered.

◆ Drugs Prescribed for Non-Approved Uses Drugs prescribed for indications approved by the Food and Drug Administration are covered. Off-label use of drugs is only covered when prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition as described herein (see the “Off-Label Drugs” provision in the “Prescription Drugs” portion of the “Covered Services and Supplies” section of the EOC).

◆ Drugs Prescribed for Non-Covered Services Drugs prescribed for a condition or treatment that is not covered by this Plan are not covered.

◆ Food and Drug Administration (FDA) Supply amount (for any number of days) which exceeds Health Net's or the FDA's indicated usage recommendation are not covered.

◆ Hypodermic Syringes and Needles Hypodermic syringes and needles are limited to insulin needles, syringes, and reusable pen devices. All other syringes, devices and needles are not covered.

◆ Injectable Drugs Injectable drugs are limited to insulin and sexual dysfunction drugs when prescribed by a Physician. Drugs that are surgically implanted are not covered, except as specifically stated.

◆ Lost, Stolen, or Damaged Drugs Drugs that are lost, stolen, or damaged are not covered. You will have to pay the retail price for replacing them.

◆ Nonparticipating Pharmacies Drugs dispensed by Nonparticipating Pharmacies are not covered, except as specified in the "Drugs Dispensed by a Nonparticipating Pharmacy" provision of "Covered Services and Supplies" of the EOC.

◆ Nonprescription (Over-the-Counter) Drugs, Devices and Supplies Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other non-Prescription Drug or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order or a drug where there is a nonprescription equivalent is not covered, even if a Physician writes a Prescription Drug Order for such drug, equipment or supply.

If a drug that is previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, this drug and similar agents that have comparable clinical effect(s), will be covered only when Prior Authorization is obtained from Health Net.

◆ Quantity Limitations Some drugs are subject to specific quantity limitations per copayment.

◆ Sexual Dysfunction Drugs Drugs (including injectable medications) prescribed for treating organically based sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual Dysfunction drugs are not available through the mail order program.

◆ Smoking Cessation Drugs used to reduce or cease smoking or for nicotine addiction are not covered.

◆ Unit Dose or "Bubble" Packaging Individual doses of medication dispensed in plastic, unit dose, or foil packages and dosage forms used for convenience as determined by Health Net, are only covered when Medically Necessary or when the medication is only available in that form.

Prosthetics and Corrective Appliances Any expenses that specifically replace missing

body parts including, but not limited to, artificial limbs, mammary prosthesis, artificial eyes, intraocular lens implants or contact lenses after cataract surgery and colostomy supplies are not covered.

Renal Dialysis Any service or supplies related to renal analysis.

Sterilizations Any expenses for sterilization or reversal of sterilization for both male and female are not covered.

How to Get in Touch with Health Net

Call Health Net's Member Services at 1-800-676-6976, 1-800-331-1777 (Spanish), or go to Health Net's web site at www.healthnet.com for more information.

Kaiser Permanente HMO

The Kaiser Permanente Health Maintenance Organization (HMO) is available only to employees and their eligible dependents living within the Kaiser zip code service areas of Los Angeles, Orange, Riverside, San Bernardino, San Diego, Kern and Ventura Counties. Certain outlying zip codes within the County are not eligible for coverage through Kaiser Permanente. Please contact Kaiser Permanente's Member Services number to verify that you are in an eligible service area.

How the Plan Works

Kaiser Permanente providers (e.g., physicians, hospitals, etc.) contract exclusively with Kaiser Permanente facilities around the country. You have access to virtually full-service, unlimited medical care at little or no additional cost. However, you must use Kaiser Permanente's physicians, hospitals and other approved health care providers. Otherwise, you will not be eligible to receive benefits, except in a life-threatening situation, such as an out-of-area urgent or emergency situation. The County has also contracted for premiums to cover durable medical equipment. See the durable medical equipment insert located in your materials from Kaiser Permanente for specific benefit information.

Co-payments For most routine care, you pay $10. For other services, co-payments may range from $5 to $100.

Deductible Under Kaiser Permanente, you pay no deductible and your out-of-pocket annual expenses are limited to $1,500 per person or $3,000 per family.

Hospitalization Kaiser Permanente will coordinate all non-emergency admissions.

Emergency Care If you think you have an emergency medical condition and cannot safely go to a Plan hospital, call 911 or go to the nearest hospital. Please see your Evidence of Coverage for more details on your coverage and benefits.

Out-of-Area Care If you need medical care and cannot get to a Kaiser Permanente facility, call the 800 number on the back of your ID card for guidance.

Claim Forms Under Kaiser Permanente, you do not have to file claim forms except for out-of-area urgent or emergency care.

How to Enroll

New employees must enroll within 30 days of hire into an eligible position.

Call Kaiser Permanente's Member Services at (800) 464-4000 if you

- Have a benefits question
- Need a member identification (ID) card
- Have an eligibility question
- Have a claims question
- Want to file a grievance

What's Covered

Kaiser Permanente benefits include routine checkups, physicals, vision exams, hearing exams, pediatric checkups and health education to help keep you and your family healthy. Please refer to the Medical Plans Comparison Chart in this booklet for key covered expenses. The Mental Health Parity Law (AB88) requires coverage for the diagnosis and medically necessary treatment services for severe mental illness of a person of any age. Coverage must be provided for these mental health services in the same way that other medical conditions are covered (e.g., same co-payments and limits). The nine specific diagnoses identified as severe mental illnesses are: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder (Manic-Depressive Disorder), Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Development Disorder or Autism, Anorexia Nervosa and Bulimia Nervosa.

What's Not Covered

Service in this section means any treatment, therapeutic or diagnostic procedure, drug, equipment, or device. When a service is excluded, all other services that are necessary for the excluded service, and that would otherwise be a covered benefit, are also excluded.

The following are excluded from your Kaiser Permanente coverage:

- All services and supplies (other than artificial insemination) related to conception by artificial means, such as, but not limited to: ovum transplants; gamete intra-fallopian transfer (GIFT); donor semen or eggs, and services and supplies related to their procurement and storage; in vitro fertilization (IVF); zygote intra-fallopian transfer (ZIFT)
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia), and astigmatism
- Care for conditions arising from military service that are reasonably available from the Veterans Administration
- Care in an intermediate care facility
- Chiropractic services and supplies
- Comfort, convenience, or luxury equipment or features
- Custodial care
- Dental care and dental X-rays
- Drugs, supplies, and supplements needed in connection with a service not covered
- Durable medical equipment used to administer drugs (covered only as described in the Kaiser Permanente materials)
- Durable medical equipment for comfort, convenience, or luxury equipment or features; exercise or hygiene equipment; dental appliances; non-medical items such as sauna baths or elevators; modifications to your home or car; devices for testing blood substances, except blood glucose monitors for diabetics; electronic monitors of the heart or lungs except infant apnea monitors
- Experimental or investigational services
- Hearing aids or tests to determine their efficacy
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation
- Home health services and supplies do not include custodial care, homemaker services and supplies or care that the home health committee determines may be appropriately provided in a plan medical office, plan hospital, or skilled nursing facility and Kaiser Permanente provides or offers to provide that care in one of these facilities
- Living and transportation expenses for any person, including the Member, for transplantation of organs
- Mental health services and supplies after diagnosis for conditions that, in the professional judgment of a plan physician or

Coverage under the plan will terminate on the earliest of the conditions listed below. Termination will be effective on the date indicated in the official plan document:

- Your employment terminates
- The Group Agreement terminates
- You are no longer eligible for County benefits
- You become covered under another health plan or under any other plan offered in connection with the County

other plan mental health professional, are not subject to significant improvement through relatively short-term therapy; these excluded conditions include chronic psychosis, chronic organic brain syndrome, intractable personality disorders, and mental retardation; Kaiser Permanente covers visits for the purpose of monitoring outpatient drug therapy for these conditions, but Kaiser Permanente does not cover outpatient drugs unless they are covered under the drugs, supplies, and supplements section of the plan document; services and supplies for patients who, in the judgment of a plan physician or other plan mental health professional, are seeking services and supplies for other than therapeutic purposes; psychological testing for ability, aptitude, intelligence, or interest

- Plastic surgery or other cosmetic services and supplies, except those specifically listed in the reconstructive surgery section of the plan document that are primarily intended to improve your appearance, or will not result in significant improvement in physical function
- Routine foot care services and supplies that are not medically necessary
- Services and supplies that an employer is required by law to provide
- Services and supplies that a government agency is required by law to provide
- Services and supplies not available in the Kaiser Permanente service area
- Services and supplies related to sexual reassignment
- Services and supplies covered by Worker's Compensation or an employee's liability law
- Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement; a surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child
- Services and supplies in a specialized facility for alcoholism, drug abuse, or drug addiction except as specifically stated in the alcohol and drug dependency benefits section of the plan; in appropriate cases, Kaiser Permanente will provide a referral to these facilities for non-covered services and supplies; services will be discontinued if the Member becomes disruptive or physically abusive
- Services and supplies to reverse voluntary, surgically induced infertility
- Specific prosthetic and orthotic devices including: eyeglasses and contact lenses; hearing aids; dental appliances; non-rigid supplies, such as elastic stockings and wigs; comfort, convenience, or luxury equipment or features; electronic voice-producing machines; shoes or arch supports, even if custom-made, except as specifically stated in the prosthetic and orthotic devices section of the plan document
- Services and supplies related to nonhuman or artificial organs and their implantation
- Tests to determine an appropriate hearing aid
- Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Kaiser Permanente provider

Limitations

- Coverage for sexual dysfunction drugs is limited to 50% of the retail drug cost
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living; speech therapy is limited to treatment for speech impairments of specific organic origin and treatment of articulation disorders due to congenital abnormalities of the palate
- In the event of unusual circumstances that delay or render impractical the provision of services and supplies, such as major disaster, epidemic, civil insurrection, disability of a large share of personnel, or labor disputes not involving Kaiser Permanente, Kaiser Permanente will use their best efforts to provide or arrange for all of their Members' health care; however, Kaiser Permanente will not be liable for any delay or failure in providing services; in the case of a labor dispute

involving Kaiser Permanente, nonemergency care may be postponed until after the dispute is resolved

- Some Members may refuse to accept treatments that are recommended by the plan physician for a particular condition; if you refuse to accept a treatment recommended by your plan physician, and he or she advises you that there is no professionally acceptable alternative, you may get a second opinion from another plan physician; if you refuse to accept a recommended treatment from either plan physician, Kaiser Permanente has no further responsibility to provide any alternative treatment you may request

Reductions

- Benefits are reduced by any benefits that a Member is entitled to under Medicare except when Medicare is secondary payor by law
- If you become ill or injured through the fault of a third party and you collect any money from the third party or from his or her insurance company, you must reimburse Kaiser Permanente for any services and supplies Kaiser Permanente covers for that injury or illness; alternatively, Kaiser Permanente may file a claim against the third party on their own behalf for the value of the services and supplies Kaiser Permanente covers for that injury or illness
- Kaiser Permanente will seek reimbursement from the medical expense provisions of any motor vehicle insurance covering you, and any liability insurance that provides payment for injuries or illness to you; you must submit to Kaiser Permanente all consents, releases, and other documents necessary for Kaiser Permanente to obtain payment

How to Get in Touch with Kaiser Permanente

Please call Member Services, available seven days a week from 7:00 a.m. to 7:00 p.m., at 1-800-464-4000, or go to Kaiser Permanente's web site at www.kp.org for more information.

Blue Cross Prudent Buyer PPO

The Prudent Buyer is a preferred provider organization, or "PPO." A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. With this PPO, you may choose the level of benefits you receive based on the providers you use when you receive care.

The Prudent Buyer PPO puts you in control of your benefits. You choose whether or not to receive care from an in- or out-of-network provider. You do not need a primary care physician (PCP) to authorize referrals to specialists.

How the Plan Works

Under the PPO, you may obtain care from an in-network or out-of-network provider. It's your choice. However, when you receive your medical care from in-network, or "PPO providers," the plan pays 80% of most covered expenses. Some covered expenses are paid only after you have paid the deductible. If you use out-of-network providers, benefits will be 70% of Usual, Customary, and Reasonable (UCR) services for the area. You will pay 30% of UCR and all charges above UCR. With out-of-network providers, the plan cannot guarantee that your chosen provider will charge fees common to the area, so your out-of-pocket costs could exceed 30%.

Deductible You pay a calendar year deductible of $250 per individual or $750 per family before the plan pays for certain services obtained from an in-network ("participating") or out-of-network ("nonparticipating") provider.

Hospitalization To avoid a $250 pre-certification deductible, your provider must contact Blue Cross in advance of hospitalization. While many physicians will arrange pre-certification on behalf of their patients, you are advised to call Blue Cross at 1-800-274-7767. This number is listed on the back of your Blue Cross ID card.

Warning

Under the Blue Cross Prudent Buyer PPO, be sure to obtain pre-certification for hospitalization. If you don't, you will have to pay a pre-certification deductible of $250.

Emergency Care If you need emergency services, get help immediately. If you are admitted to a hospital, you or your physician must call Blue Cross at 1-800-274-7767 as soon as possible.

Out-of-Area Care If you need care while away from home, Blue Cross is affiliated with the Blue Cross/Blue Shield network across the United States. You may call Blue Cross' Member Services at 1-800-274-7767 to obtain a listing of in-network physicians in the area. You will receive the in-network level of benefits at any contracted Blue Cross/Blue Shield network provider. If a network provider is not available, you may obtain out-of-network care anytime, anywhere.

How to Enroll

New employees must complete a Medical Plan Enrollment/Change form within the first 30 days of hire into an eligible position, and return it to their payroll clerk.

Call Blue Cross' Member Services if you:

- Have a benefits question
- Need hospital pre-certification
- Need a provider directory
- Need a member identification (ID) card
- Have an eligibility question
- Have a claims question

What's Covered

While covered under the PPO, you can take advantage of comprehensive medical benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to the maximum benefit amounts. Please refer to the Medical Plans Comparison Chart in this booklet for key covered expenses.

What's Not Covered

No payment will be made under the Blue Cross PPO plan for, or in connection with, any of the items below:

- Acupuncture treatment except as specifically stated in the plan
- Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatoses or acupuncture points
- Air purifiers, air conditioners or humidifiers
- Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or stigmatism; contact lenses and eyeglasses required as a result of this surgery
- Any experimental or investigative procedure or medication
- Any non-prescription, over-the-counter patent or proprietary drug or medicine
- Any supplies for comfort, hygiene or beautification
- Any services or supplies furnished in connection with the diagnosis and treatment of infertility including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer
- Any services provided by a local, state or federal government agency, except when payment under the plan is expressly required by federal law or state law
- Artificial insemination or in vitro fertilization procedures and any related laboratory procedures
- Braces, other orthodontic appliances or orthodontic services
- Conditions that result from the Member's commission of, or attempt to, commit a felony
- Any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy
- Contraceptive devices prescribed for birth control
- Consultations provided by telephone or facsimile machine
- Cosmetics, dietary supplements, health or beauty aids
- Cosmetic dental surgery or other dental services for beautification
- Cosmetic surgery or other services solely for beautification or to improve appearance; this

exclusion does not apply to reconstructive surgery to restore a bodily function, to correct a deformity caused by injury or to medically necessary surgery performed to restore symmetry incident to a mastectomy; cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons

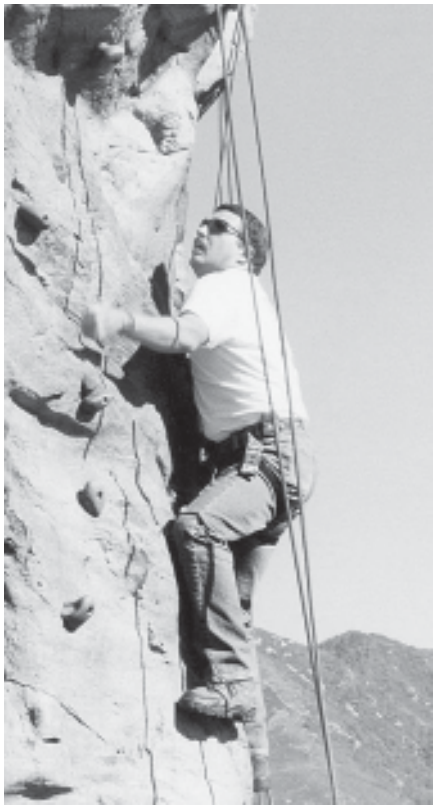
- Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically provided for under the dental care benefits of the plan for provision of medical care that is covered
- Educational services or nutritional counseling, except as specifically provided or arranged by Blue Cross, or as stated under this plan
- Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a physician
- Eye glasses except as specifically stated in the prosthetics devices provisions of the plan
- Food supplements
- Hearing aids
- Hyperkinetic syndromes and/or attention deficit disorders, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood

- Infertility treatment, family planning or birth control services, except as specifically provided for under the plan
- Inpatient or outpatient services of a private duty nurse
- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy; custodial care or rest cures, except as specifically provided under the plan; services provided by a rest home, a home for the aged, a nursing home or any similar facility; services provided by a skilled nursing facility, except as specifically stated in the plan
- Mental or nervous disorders or alcohol or drug dependence, except as specifically provided for under the plan
- Optometric services, eye exercises including orthoptics
- Orthopedic shoes (except when joined to braces) or shoe inserts
- Outpatient speech therapy, except as specifically provided for under the plan
- Outpatient occupational therapy, except by a home health agency, visiting nurse association, hospice or home infusion therapy provider as specifically stated in the medical care that are covered provisions of the plan
- Outpatient prescription drugs or medications and insulin, except as specifically provided for under the plan
- Prescription and non-prescription diabetic supplies, except as specifically stated in the plan
- Programs to alter one's lifestyle which may include, but are not limited to, diet, exercise, imagery or nutrition; this exclusion will not apply to cardiac rehabilitation programs approved by the plan
- Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically stated in the plan

– Procedures or treatments to change characteristics of the body to those of the opposite sex
– Routine hearing tests, except as specifically provided under the preventive care provisions of the plan
– Routine eye exams and routine eye refractions, except as specifically provided for in the plan
– Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated in the well baby and well child care, cervical cancer screening, mammograms, screening for blood lead levels, or hepatitis B and varicella zoster immunizations provisions of this plan
– Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically provided for under the plan
– Services not specifically listed in the plan as covered services
– Services for which the member is not legally obligated to pay or for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital; such a hospital must meet the following guidelines:
• It must be internationally known as being devoted mainly to medical research

• At least 10% of its yearly budget must be spent on research not directly related to patient care
• At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care
• It must accept patients who are unable to pay
• Two-thirds of its patients must have conditions directly related to the hospital's research
– Services or supplies that are not medically necessary, as defined in the plan
– Services or supplies furnished and billed by a provider outside the United States, unless such services are furnished in connection with urgent care or an emergency
– Services received before the Member's effective date
– Services received after the Member's coverage ends, except as specifically stated under the extension of benefits provision of the plan
– Services or supplies for the treatment of a total disability if: (1) you were covered under the prior plan; (2) you were totally disabled on the date the prior plan terminated; and (3) you are entitled to an extension of benefits under Section 1399.62 of the California Health and Safety Code, Section 10128.2 of the California Insurance Code, or to any similar extension of coverage for the totally disabling condition
– Services primarily for weight reduction or treatment of obesity; this exclusion will not apply to treatment of morbid obesity, as determined by Blue Cross, if Blue Cross authorizes the treatment in advance as medically necessary and appropriate
– Smoking cessation programs or treatment of nicotine or tobacco use
– Sterilization reversal
– Treatment of chronic pain, except as specifically provided for under the plan
– Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any Worker's Compensation, employer's liability law or occupational disease law, even

if the member does not claim those benefits; if there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to Worker's Compensation, benefits will be provided, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as set forth in the Reimbursement for Acts of Third Parties provision of the plan



Limitations

- Blue Cross is entitled to reimbursement of benefits paid if the Member recovers damages from a legally liable third party
- The benefits of this plan may be reduced if the Member has any other group health, dental, prescription drug or vision coverage so that the services received from all group coverages does not exceed 100% of the covered expense

How to Get in Touch with Blue Cross

Call Blue Cross' Member Services at 1-800-288-2539, or go to Blue Cross' web site at www.bluecrossca.com for more information.

Dental Plans Comparison Chart

			DELTA CARE	DELTAPREFERRED	
Category	*ADA Dental Codes*	*Description*	*Network Only (You pay...)*	*In-Network (You pay...)*	*Out-of-Network (You pay ...plus any costs over UCR)*
Preventive Care	00120	Periodic oral examination	$ 0	0%	0%+
	00210	Full mouth X-ray, 1 set per year or as needed	0	0%	0%+
	00220	Periapical (single tooth) X-ray	0	0%	0%+
	09110	Emergency, palliative treatment of dental pain	5.00	0%	0%+
	09430	Office visit for observation	0	0%	0%+
	00460	Pulp vitality test	0	0%	0%+
	01201	Topical fluoride (child)	0	0%	0%+
	01351	Sealant (per tooth)	5.00	0%	0%+
	00470	Diagnostic models	0	0%	0%+
	01110	Prophylaxis (to remove tartar/stains)	0	0%	0%+
	00125	Broken appointment (24 hours minimum notice)	10.00	0%	0%+
Restorative Dentistry	02110	Amalgam (“silver” fillings) on primary teeth: 1 surface	$ 0	10%	10%+
	02120	Amalgam on primary teeth: 2 surfaces	0	10%	10%+
	02130-31	Amalgam on primary teeth: 3 or 4 surfaces	0	10%	10%+
	02140	Amalgam on permanent teeth: 1 surface	0	10%	10%+
	02150	Amalgam on permanent teeth: 2 surfaces	0	10%	10%+
	02160-61	Amalgam on permanent teeth: 3 or 4 surfaces	0	10%	10%+
	02330	Composite resin (white), anterior teeth only, 1 surface	0	10%	10%+
	02951	Pin retention	10.00	10%	10%+
	01510	Space maintainers	15.00	10%	10%+
Periodontics	04240	Gingival flap, per quadrant	$ 75.00	10%	10%+
	04341	Periodontal scaling (deep cleaning), per quadrant	0	10%	10%+
	04260	Osseous surgery (reshaping bone), per quadrant	150.00	10%	10%+
	04210	Gingivectomy/gingivoplasty (gum surgery), per quadrant	75.00	10%	10%+
	04220	Gingival curettage, per quadrant	0	10%	10%+
	04910	Periodontal maintenance procedures	0	10%	10%+
Endodontics	03110	Pulp capping	$ 0	10%	10%+
	03220	Therapeutic pulpotomy	0	10%	10%+
	03310	Anterior (front) teeth root canal therapy	30.00	10%	10%+
	03320	Bicuspid root canal therapy	60.00	10%	10%+
	03330	Molar root canal therapy	90.00	10%	10%+
	03920	Hemisection	100% UCR	10%	10%+
	03450	Root amputation (per root)	0	10%	10%+
	03410	Apicoectomy	50.00	10%	10%+
	03426	Periradicular surgery (each additional root)	50.00	10%	10%+
	03430	Retrograde filling (per root)	50.00	10%	10%+

Oral Surgery	07286	Biopsy of soft oral tissue	$ 0	10%	10%+
	07110	Uncomplicated extraction, single tooth	0	10%	10%+
	07220	Extraction—impacted soft tissue, per tooth	0	10%	10%+
	07230	Extraction—impacted partially bony, per tooth	30.00	10%	10%+
	07240	Extraction—impacted completely bony, per tooth	40.00	10%	10%+
	09215	Local anesthesia	0	10%	10%+
	09220	General anesthesia (first 30 minutes)	100% UCR	10%	10%+
	07320	Alveoloplasty (reshape bone) per quad, w/out extraction	40.00	10%	10%+
	07310	Alveoloplasty (reshape bone) per quad, with extraction	30.00	10%	10%+
	07130	Removal of residual/exposed tooth roots	0	10%	10%+
	07510	Incision and drainage of abscess	0	10%	10%+
	07960	Frenulectomy (includes frenectomy or frenotomy)	0	10%	10%+
	07350	Vestibuloplasty	100%UCR	10%	10%+
Crowns and Bridges	06790	Crown—full cast high noble metal (gold)	$ 60.00	30%	30%+
	06780	Crown—3/4 cast high noble metal (gold)	60.00	30%	30%+
	02792	Crown—full cast noble metal (silver)	60.00	30%	30%+
	02810	Crown—3/4 cast metallic	60.00	30%	30%+
	02752	Crown—porcelain fused to noble metal (silver)	60.00	30%	30%+
	02722	Crown—resin with noble metal (silver)	60.00	30%	30%+
	02710	Crown—resin (laboratory)	40.00	30%	30%+
	06930	Recement fixed partial denture	0	30%	30%+
	02920	Recement crown	0	30%	30%+
Prosthetics	05110	Complete upper denture	$ 75.00	30%	30%+
	05120	Complete lower denture	75.00	30%	30%+
	05211	Upper partial denture—resin base	85.00	30%	30%+
	05212	Lower partial denture—resin base	85.00	30%	30%+
	05750-51	Reline upper or lower denture, laboratory	30.00	30%	30%+
	05510	Repair broken denture, no tooth damage	15.00	30%	30%+
	05410	Complete denture adjustment	0	30%	30%+
	05520	Replace broken tooth on denture	5.00	30%	30%+
	05710-11	Rebase complete maxillary or mandibular denture	30.00	30%	30%+
	06210	Denture pontics, cast high noble metal (gold)	60.00	30%	30%+
	06720	Denture crown, resin with high noble metal (gold)	60.00	30%	30%+
Orthodontics		Start Up Fees (excluding records)	$350	50% plus any cost over $1,500 (max. lifetime benefit $1,500)	50% plus any cost over UCR (max. lifetime benefit $1,500)
		Co-payment	$1,450.00		
Calendar Year Benefit Maximum			None	$1,500 per person (excluding orthodontia)	$1,500 per person (excluding orthodontia)

Under DeltaPreferred, you may obtain dental care in- or out-of-network AND you have a good selection of in-network providers from which to choose.

DeltaPreferred

DeltaPreferred is administered by Delta Dental. DeltaPreferred allows you to choose to receive care from a network provider or from an out-of-network provider. It is your choice. You may change between in- and out-of-network dentists anytime without notifying Delta Dental in advance.

How the Plan Works

In-Network When you receive your dental care from a DeltaPreferred network dentist, you will pay a percent of the dentist's discounted DeltaPreferred rates: 0% for preventive services, 10% for basic restorative services, and 30% for advanced restorative services. To know what your cost will be in advance, you may request a pre-authorization. To obtain a DeltaPreferred *Provider Directory*, please call Delta Dental at 1-800-765-6003.

Out-of-Network When you receive care from an out-of-network dentist, you will pay a percentage (0% for preventive services, 10% for basic restorative services, and 30% for advanced restorative services) of the dentist's non-discounted fees plus any charges over Usual, Customary, and Reasonable (UCR) as established by Delta Dental. Your share of the cost will be the difference between what the plan covers out-of-network and what your out-of-network dentist is charging you. This cost will vary by provider.

For example: let's assume you had an out-of-network periodontic root planning and your out-of-network dentist charged $125. If DeltaPreferred determined that UCR for that service was $100 then you would pay 10% of $100 or $10 plus any cost over UCR of $25. Your total out-of-pocket expense for this procedure would be $35. If you used a network dentist, the average contracted charge for this procedure is $85. You would pay 10% of $85 or $8.50. (Note: the numbers cited are for example purposes only. They may not be the actual rates associated with this procedure.)

Copayments Copayments vary by procedure. However, most preventive services will be provided at no cost to you from in-network providers and out-of-network providers (within UCR limitations).

Deductible Under DeltaPreferred, you pay no deductible.

Orthodontia Coverage You and your covered dependents may obtain orthodontic care from any licensed orthodontist of your choice. The plan pays 50% of your orthodontia expenses up to a lifetime maximum of $1,500. For current Delta Care members who are currently under an orthodontist's care, your orthodontia treatment will be continued by DeltaPreferred up to the maximum benefit limit allowed under your previous plan.

Emergency Care In an emergency, get the care you need. The plan will pay benefits based on whether your emergency care was received from an in- or out-of-network dentist.

Out-of-Area Care If you need dental care away from home, call Delta Dental at 1-800-765-6003. If possible, you will be directed to an available in-network dentist. If an in-network dentist is not available, you will receive the out-of-network benefit automatically.

Claim Forms Under DeltaPreferred, your network dentist will submit a standard claim form directly to Delta Dental. If your dentist needs a claim form, call the Delta Dental Claims Department at 1-800-765-6003.

If your dentist is an out-of-network dentist, Delta Dental will make claim payments directly to you. It is your responsibility to pay your dentist for services rendered.

How to Enroll

New employees must complete a Dental Plan Enrollment/Change form within the first 30 days of hire into an eligible position and return it to their payroll clerk. You must remain in the plan a minimum of two (2) years.

Call Delta Dental if you:

- Have a benefits question
- Need a provider directory
- Need a member ID card
- Have an eligibility question
- Have a claims question

What's Covered

While covered under DeltaPreferred, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to the maximum benefit amounts. Please refer to the *Dental Plans Comparison Chart* in this booklet for covered expenses.

What's Not Covered

- Services for injuries or conditions which are covered under Workers' Compensation or Employer's Liability Laws.
- Services which are provided to the Enrollee by any federal or state government agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except as provided in California Health and Safety Code Section 1373(a).
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to: cleft palate, upper or lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
- Prosthodontic services or any Single Procedure started prior to the date the person became eligible for such services under this plan.
- Prescribed or applied therapeutic drugs, premedication or analgesia.
- Experimental procedures.
- All hospital costs and any additional fees charged by the Dentist for hospital treatment.
- Charges for anesthesia, other than general anesthesia administered by a licensed Dentist in connection with covered Oral Surgery services.
- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue).
- Implants (materials implanted into or on bone or soft tissue) or the repair or removal of implants or any treatment in conjunction with implants, except as provided under Limitations.
- Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues.
- Replacement of existing restorations for any purpose other than active tooth decay.
- Intravenous sedation, occlusal guards and complete occlusal adjustment.

Limitations

- Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, provided in a calendar year are Benefits while the patient is an Enrollee under any Delta program.
- Delta pays for full-mouth x-rays only after five years have elapsed since any prior set of full-mouth x-rays was provided under any Delta program.
- Bitewing x-rays are provided on request by the Dentist, but not more than twice in any calendar year for children to age 18, or once in any calendar year for adults ages 18 and over, while the patient is an Enrollee under any Delta program.
- Diagnostic casts are a Benefit only when made in connection with subsequent

orthodontic treatment covered under this program.

- Only the first two cleanings, fluoride treatments, or Single Procedures which include cleaning, or combination thereof, provided to a patient in a calendar year while he or she is an Enrollee under any Delta program are Benefits under this program.

- Sealant Benefits include the application of sealants only to permanent first molars up to age nine and second molars up to age 14 if they are without caries (decay), or restoration on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.

- Direct composite (resin) restorations are Benefits on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optional services and Delta's payment is limited to the cost of the equivalent amalgam restorations.

- Crowns, Jackets, Inlays, Onlays or Cast Restoration are Benefits on the same tooth only once every five years while the patient is an Enrollee under any Delta program, unless Delta determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

- Prosthodontic appliances that were provided under any Delta program including, but not limited to, fixed bridges and partial or complete dentures, will be replaced only after five years have passed, unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory.

Replacement of a prosthodontic appliance not provided under a Delta program will be made if it is unsatisfactory and cannot be made satisfactory.

- Delta will pay the applicable percentage of the Dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture, up to a maximum fee allowance which is at least the Prevailing Fee for a standard denture. (A "standard" complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and which is constructed using accepted and conventional procedures and materials.) The maximum allowance is revised periodically as dental fees change. Any denture and/or related service for which a charge is made which exceeds this allowance is an optional service, and the patient is responsible for the portion of the Dentist's fee which exceeds the maximum allowance.

- Implants (materials implanted into or on bone or soft tissue) or their removal are not Benefits under this plan. However, if implants are provided in association with a covered prosthodontic appliance, Delta will allow the cost of a standard complete or partial denture toward the cost of the implant procedures and prosthodontic appliances. If Delta makes an allowance toward the cost of such procedures, Delta will not pay for any replacement placed within five years thereafter.

- If an Enrollee selects a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta will pay the applicable percentage of the lesser fee and the patient is responsible for the remainder of the Dentist's fee. For example: a crown, where a silver filling would restore the tooth, or a precision denture, where a standard denture would suffice.

How To Get In Touch With DeltaPreferred

For information about DeltaPreferred, call Delta Dental at 1-800-765-6003.

Delta Care

Delta Care is a prepaid, "HMO-style" dental plan covering more than 650,000 Californians through a network of private practice dental offices. PMI is an affiliate of Delta Dental Plan of California and administers the Delta Care Plan.

How the Plan Works

When you enroll in Delta Care, you must select a dental office from the *Participating Dental Offices* directory. If you need a directory, call PMI at 1-800-422-4234. After you select your dental office, this office becomes the "primary care dental office" for you and all covered dependents. You must go to this office for all of your dental services. If you do not obtain dental services through your primary care dental office, or if PMI has not authorized services elsewhere, you will ***not be covered.***

Copayments For most basic and preventive services, you pay no copayment. For other services, you pay a small fee.

Deductible Under the Delta Care Plan, you pay no deductible.

Claim Forms Under the Delta Care Plan, you have no claim forms to file.

Orthodontia Coverage You and your covered dependents may obtain orthodontic care from any Delta Care orthodontist of your choice. You pay a $350 startup fee along with a $1,450 copayment for 24 months of usual and customary treatment. You can obtain a list of Delta Care orthodontists by calling Member Services at 1-800-422-4234.

Emergency Care If you need emergency services, call your primary care dental office. If your primary care dental office is unavailable, call PMI at 1-800-422-4234 and you will be directed to an available Delta Care dentist.

Out-of-Area Care If you need dental care away from home, call PMI at 1-800-422-4234 and you will be directed to an available Delta Care dentist. If a Delta Care dentist is not available within a 35-mile radius, obtain care from a nearby licensed dentist and then submit a claim to PMI. You must submit your claim within 12 months (365 days) of the date you obtained out-of-area (out-of-network) care. You will be reimbursed at the out-of-area/ out-of-network rate, up to $100.

How to Enroll

New employees must enroll within 30 days of hire into an eligible position.

Delta Care Features

- No claim forms
- No deductibles
- No annual maximum benefit
- Pre-existing conditions are not excluded, except for work in progress
- Out-of-pocket savings are substantial
- Specialty services available

Call Delta Care if you:

- Need to select a new Delta Care dentist
- Have a benefits question
- Need a provider directory
- Need a member ID card
- Have an eligibility question
- Have a claims question

Your dentist can help you avoid dental disease by:
- Removing calculus from your teeth
- Treating dental disease if it has already started
- Teaching you how to control plaque
- Providing other preventive care

But the most important person who cares for your teeth is you! Only you can give your teeth the daily care they need. Brush and floss every day to remove plaque and help yourself to good dental health.

What's Covered

While covered under the Delta Care Plan, you can take advantage of comprehensive dental benefits. The plan pays benefits for covered expenses you incur while covered under the plan, subject to plan exclusions and limitations. Please refer to the *Dental Plans Comparison Chart* in this booklet for covered expenses.

What's Not Covered

- General anesthesia and the services of a special anesthesiologist.
- Cosmetic dental care.
- Dental conditions arising out of and due to Enrollee's employment or for which Worker's Compensation is payable; services which are provided to the Enrollee by state government or agency thereof or are provided without cost to the Enrollee by any municipality, county or other subdivision.
- Treatment required by reason of war.
- Dental services performed in a hospital and related hospital fees.
- Treatment of fractures and dislocations.
- Loss or theft of fixed and removable prosthetics (crowns, bridges, full or partial dentures, retainers).
- Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
- Any service that is not specifically listed as a covered expense.
- Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility with the Delta Care program (e.g., teeth prepared for crowns, root canals in progress).

- Congenital malformations (e.g., congenitally missing teeth, supernumerary).
- Cysts and malignancies.
- Dispensing of drugs not normally supplied in a dental office.
- Cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained or where the prognosis is poor or guarded.
- Dental services received from any dental office other than the assigned Delta Care office or a participating network specialist.
- Prophylactic removal of impactions (asymptomatic/nonpathological).
- "Specialist consultations" for noncovered benefits.
- Implant placement or removal, appliances placed on or services associated with implants including, but not limited to, prophylaxis and periodontal treatment.
- Crown lengthening procedures.

Limitations

- Accidental injury, except as noted in Accident Injury Rider; that is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth; damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits
- Prophylaxis is limited to one treatment each six month period (includes periodontal maintenance following active therapy)
- Full upper and/or lower dentures are not to exceed one each in any five year period from initial placement
- Partial dentures are not to be replaced within any five year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible
- Crown(s) and bridges are not to be replaced within any five year period from initial placement

- Denture relines are limited to one per denture during any 12 consecutive months
- Periodontal treatments (root planing/ subgingival curettage) are limited to four quadrants during any 12 consecutive months
- Full mouth debridement (gross scale) is limited to one treatment during any 12 consecutive month period
- Bitewing X-rays are limited to not more than one series of four films in any 12 month period
- Full mouth X-rays are limited to one set every 24 consecutive months
- Sealant benefits include the application of sealants only to permanent first and second molars with no decay, with no restorations and with the occlusal surface intact, for first molars up to age nine and second molars up to age 14. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application

Limitations On Orthodontic Benefits

- Orthodontic treatment must be provided by a Delta Care orthodontist
- Plan benefits cover 24 months of usual and customary orthodontic treatment
- Should an Enrollee's coverage be cancelled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee and not Delta Care will be responsible for payment of balance due of $2,300 for dependent children to age 19 and $2,500 for covered full-time students and adults; the amount will be pro-rated over the number of months to completion of the treatment and will be payable by the Enrollee on such terms and conditions as are arranged between the Enrollee and the orthodontist; start-up fees are included; start-up fees cover the initial examination, diagnosis, consultation and the retention phase, including initial construction, placement and adjustments to retainers, and office visits for a maximum period of two years

Exclusions On Orthodontic Benefits

- Pre-, mid- and post-treatment records which include cephalometrics X-rays, tracings, photographs and study models
- Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances
- Retreatment of orthodontic cases
- Treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge at orthodontist's usual, customary and reasonable fee
- Treatment in progress at inception of eligibility
- Transfer after banding has been initiated

Health Net Vision

Vision care is an employer-paid benefit (except for deductibles and copayments). For employees in the General bargaining unit, this benefit only covers the employee, it does NOT cover dependents.

The County of San Bernardino has contracted with Health Net Vision as the vision care provider. Health Net Vision is one of the largest providers of network-based vision products in California. Their comprehensive product portfolio and extensive network of providers serve nearly 500,000 throughout the state.

The County of San Bernardino is participating in the **Image** *Preferred Provider Organization* plan. This comprehensive plan offers you:

- Low deductible eye exams.
- Large network of local vision providers.
- Freedom to see any provider you choose, in- and out-of-network benefits.
- 20% discount on second pair of glasses – including sunglasses!
- Generous benefits at no additional cost when you use a Health Net Vision Preferred Provider.
- Ability to select a provider online with the *DocSearch* feature.
- Dedicated customer service number exclusively for County of San Bernardino employees.

In addition to all of this, Health Net Vision also features a full service website that will allow you to access and download valuable information about the company, the products and services, and your health. The website is also the place where you can choose a local provider with the easy to use DocSearch feature. Visit them at their web address, http://dv.healthnet.com. To use DocSearch, click on the "search" button on the home page, then click "Employer Group-Sponsored Plans," choose Vision and then enter your city, zip code and distance to provider. It's that simple!

Exclusions and Limitations

1. Charges for procedures, services or materials that are not included as Covered Charges.
2. Any portion of a charge in excess of the Maximum Benefit Allowance.
3. Expenses for any non-Standard Corrective Lens materials including, but not limited to, the following: coated, dyed, glass lens tints or laminated lenses, blended, or oversize lenses, occupational or recreational lenses, polycarbonate, safety glasses, scratch resistant, UV protection, anti-reflective, or photochromatic/photosensitive lenses.
4. Non-prescription lenses.
5. Orthoptics, vision training and low vision aids and any associated supplemental testing.
6. Medical or surgical treatment of the eye including, but not limited to, Laser in Situ Keratomileusis (LASIK) and Photorefractive Keratectomy (PRK).
7. Prescription or non-prescription medications.
8. Any eye examination or any corrective eyewear required as a condition of employment.
9. Services or materials which the Company determines to be Experimental, cosmetic or not Medically Necessary.

10. Any service or material not prescribed by an ophthalmologist, optometrist or registered dispensing optician.
11. Services and materials furnished in conjunction with excluded services and materials.
12. Services and materials for repair or replacement of broken, lost or stolen lenses, contact lenses or frames.
13. Services and materials that a Covered Person received during a Service Interval under any other plan offered by the Company or one of the Company's affiliates.
14. Charges incurred before a Covered Person's effective date of coverage under the Policy or after such coverage terminates.
15. Services or materials received as a result of disease, defect, or injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit a felony.
16. Services and materials obtained while outside the United States, except for Emergency Vision Care.
17. Services or materials resulting from, or in the course of, Your or a Dependent's regular occupation for pay or profit for which You or Your Dependent are entitled to benefits under any Worker's Compensation Law, Employer's Liability Law or similar law. You must promptly claim and notify the Company of all such benefits.
18. As follows:

- Charges payable or reimbursable by or through a plan or program of any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a governmental agency of the United States. However, the Company will always reimburse any state or local medical assistance (Medicaid) agency for Covered Services and Materials;
- Charges are not imposed against the person or for which the person is not liable;
- Charges are reimbursable by Medicare Parts A and Part B. If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his or her benefits under this Policy will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law. However, for persons insured under Employers who notify the Company that they employ 20 or more Employees during the previous business year, this exclusion will not apply to an Actively Working Employee and/or his spouse who is age 65 or older if the Employee elects coverage under this Policy instead of coverage under Medicare.

19. Services, procedures, or materials for which a charge would not have been made in the absence of insurance.

How to Get in Touch with Health Net Vision

For further information, please contact the Customer Service Department at 1-800-880-3135. The Customer Service hours are Monday – Friday, 7:00 a.m. to 7:00 p.m., and Saturday 8:00 a.m. to 1:00 p.m.

Image Vision Plan 34CSB – General/Safety Employees

(Contact the Employee Benefits and Services Division for Safety and Exempt Employees' benefits)

Deductible, coinsurance, benefits, exclusions and limitations are subject to the provisions of the Certificate. If there are any inconsistencies in the provisions of the Certificate and this Schedule of Benefits, the provisions of the Certificate shall govern.

	Preferred Provider In-Network Plan Pays *	Non-Preferred Provider Out-of-Network Plan Pays*
Examination Deductible (per covered person) $10		
Examination One complete visual examination every 12 months	**100%**	Up to a Maximum Benefit Allowance of **$45**
Frames One frame every 24 months	Up to a Maximum Benefit Allowance of **$85**	Up to a Maximum Benefit Allowance of **$45**
Standard Corrective Lenses One pair every 12 months includes standard single vision, bifocal, trifocal or lenticular clear glass or plastic lenses	**100%** (Progressive lenses up to a Maximum Benefit Allowance of **$75)**	Up to a Maximum Benefit Allowance of: Single vision.....$40 Bifocal up to.....$55 Trifocal up to.....$70 Progressive .....$70 Lenticular: Single vision up to .....$125 Multifocal up to.....$125
Medically Necessary Contact Lenses** One pair or single lens every 12 months in lieu of all other vision materials	Up to a Maximum Benefit Allowance of **$250 ($125 per lens)**	Up to a Maximum Benefit Allowance of **$205 ($102.50 per lens)**
Non-Medically Necessary (Cosmetic) Contact Lenses** One pair every 12 months in lieu of all other vision materials	Up to a Maximum Benefit Allowance of **$85**	Up to a Maximum Benefit Allowance of **$85**

* After satisfaction of applicable Deductibles for exam and materials combined, all Preferred Provider payments are based upon negotiated rates or are limited to Maximum Retail Benefit Allowances. All Non-Preferred payments are limited to Maximum Retail Benefit Allowances. Covered Persons are responsible for any provider charges in excess of Maximum Benefit Allowances.

** Medically Necessary Contact Lenses are lenses that are needed due to certain eye defects or diseases and must be prior authorized.

Second Pair

Health Net Vision recognizes that many members prefer to have a second pair of frames and lenses. The first pair of frames and corrective lenses are covered by the plan, however, Health Net Vision has negotiated with Preferred Providers and allows them to extend a 20% discount from their Reasonable and Customary fees for a second pair of frames and corrective lenses (including, but not limited to, prescription sunglasses, VDT prescription in lieu of bifocals, safety glasses, occupational or recreational glasses) at the same time as the first pair of frames and corrective lenses. Of the two pairs of frames and corrective lenses, the more expensive pair will be defined as the "first pair" while the least expensive pair will be considered the "second pair."

Medical Expense Reimbursement (FSA) Plan

You can save money by paying for certain medical care expenses with pre-tax dollars. How? By participating in a County sponsored and administrated Medical Expense Reimbursement (FSA) Plan available to eligible employees. This is a type of Flexible Spending Account or FSA.

How the Plan Works

When you participate in the FSA, you elect to set aside a portion of your bi-weekly salary before taxes are calculated and taken out. The money you set aside is placed into a separate account, which can be used to pay for qualifying medical care expenses that you, your spouse, and dependent(s) incur. There are some expenses that you know you will incur during the year that will not be reimbursed by your group health plan, other insurance, or other accident or health plan. These expenses include amounts paid for hospital bills, doctor and dental bills or co-pays, chiropractic care, prescription drugs, and some nonprescription (over-the-counter) drugs. Normally you would pay for these expenses with after-tax dollars. However, with the FSA, you would reimburse yourself from your account with your pre-tax dollars.

Maximum/Minimum Contribution Amounts

Employees in the Administrative Services; Clerical; Craft, Labor and Trades; Management; Professional; Supervisory; Technical and Inspection; Attorney, Specialized Peace Officer and Specialized Peace Officer-Supervisory units may contribute a maximum amount of $650 per year, or $25 per pay period, to their FSA. The minimum amount an employee may contribute is $130 per year, or $5 per pay period.

Exempt employees may contribute a maximum amount of $650 per year, or $25 per pay period, to their FSA. The minimum amount that an employee may contribute is $260 per year, or $10 per pay period.

Employees in the Safety Management and Supervisory unit may contribute a maximum amount of $1,300 per year, or $50 per pay period, to their FSA. The minimum amount an employee may contribute is $130 per year, or $5 per pay period.

Eligible Expenses

Expenses are generally considered eligible for reimbursement if the expenses are incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease. With the exception of over-the-counter medications, the expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Over-the-counter medications must be for the treatment of an existing injury or illness, not for preventive purposes. Expenses solely for cosmetic reasons generally are not considered expenses for medical care. Also, expenses that are only beneficial to one's general health (e.g. health spas, vitamins, etc.) are not considered expenses for medical care. A list of covered expenses is available on the County's intranet site at http://countyline/hr/benefits/FSAexpenses.asp.

Reimbursement

You may apply for reimbursement of qualifying medical care expenses by submitting a completed claim form to Employee Benefits and Services Division, 222 W. Hospitality Lane, 3rd Floor, San Bernardino, CA 92415-0015 no later than ninety (90) days after the end of the plan year. Invoices, receipts, bills, or other statements from an independent third party showing the amount of the qualifying medical care expenses incurred must be attached to the claim form, together with any other documentation that the Plan Administrator may request. If requesting reimbursement for over-the-counter medications, the name of the medication must appear on the receipt and the item should be circled on the receipt. Requests for reimbursement may be made as the expenses are incurred or at the end of the Plan Year. However, except for the final reimbursement claim for a Plan Year, no claim

for reimbursement of less than $25 will be processed for payment. Reimbursement requests for less than $25 will be held until other reimbursement claims are made and claims received total $25 or more.

Eligible expenses will be reimbursed, by a check issued separate from payroll and made payable directly to the participant, as soon as possible after receipt of a properly completed claim form and required documentation. If reimbursement is not received within thirty (30) days from submission of a claim, you should contact Employee Benefits and Services at (909) 386-8600.

Important Rules on Medical Expense Reimbursement (FSA) Plans

Plan very carefully! The IRS governs the terms of these plans, which means that your election to put money into an FSA is an irrevocable election. Therefore, once you have made an election to participate in the Plan, you may not revoke or change your election for the remainder of the Plan Year unless you experience a qualified Change in Status Event during the Plan Year and the requested change in your FSA election is consistent with the event.

Be conservative in your estimates! Do not contribute more money into your account than you know you will use. Why? The IRS says you must use all of the funds in your account by the end of the Plan Year or you will lose them. So, if you choose to participate in the Plan, you should take the time to conservatively estimate the amount of out-of-pocket expenses you expect to have during the Plan Year before you make your election.

At the end of the Plan Year, if any balance remains in your FSA that has not been reimbursed, you will forfeit your right to the balance; it cannot be carried forward to the next Plan Year.

NOTE: This is only a summary and partial listing of FSA Plan benefits, terms, conditions, exclusions and limitations. For a full and complete listing, please refer to the appropriate plan document. If any differences appear between this summary and the plan document, the information in the plan document shall govern.

For more information on the Medical Expense Reimbursement (FSA) Plan, contact Employee Benefits and Services Division or go on-line to www.sbcounty.gov/hr/benefits or http://countyline/hr/benefits.

Short-Term Disability (STD) Plan

The County provides Short-Term Disability (STD) benefits to employees in the event of a non-work related illness or injury that requires the employee to be off work more than seven (7) consecutive calendar days. STD benefits provide partial income replacement while the employee is off work. These benefits may be integrated with the employee's available leave hours.

Effective Dates

Employees in the Administrative Services; Craft Labor and Trades; Management; Professional; and Supervisory Units are covered by this Plan effective July 1, 1989 or the first day actively at work following this date. Employees in the Clerical; Technical and Inspection; and Attorney Units are covered by this Plan effective July 27, 2002 or the first day actively at work following this date. Employees in the Specialized Peace Officer and Specialized Peace Officer-

Supervisory Unit are covered by this Plan effective September 7, 2002 or the first day actively at work following this date. Exempt employees are covered by this Plan effective August 1, 1996 or the first day actively at work following this date. Other employees or employee groups who have been expressly approved for STD coverage by the County Board of Supervisors may also be eligible.

If you belong to one of the eligible groups described above, your coverage under the plan is automatic. Your labor association has negotiated this benefit on your behalf to replace State Disability Insurance (SDI).

However, employees who participated in SDI at any time within the eighteen (18) months immediately prior to filing an STD claim may be eligible to receive SDI benefits. An employee previously covered under SDI must apply for SDI benefits and provide a copy of the SDI determination letter. The STD benefit amount will be reduced by the amount of the SDI benefit the employee is eligible for or receiving. In the event that the SDI benefit amount is greater than the allowable STD benefit amount, no STD benefits will be paid.

Eligibility

With the exception of Exempt employees, in order to be eligible to receive Plan Benefits, all of the following conditions must be met: 1) Employee must be employed in a regular position budgeted for forty (40) hours or more per pay period; 2) Employee must have competed at least two (2) pay periods of continuous service, each with a minimum of one-half (1/2) plus one (1) hour of scheduled hours of paid time; and 3) Employee must be designated as a member of one (1) of the groups covered by this Plan.

In order for Exempt employees to be eligible to receive Plan Benefits, all of the following conditions must be met: 1) Employee must be employed in a regular County position budgeted for forty (40) hours or more per pay period; 2) Employee must have completed at least one (1) pay period of continuous service; and 3) Employee must be designated as an Exempt employee or expressly approved for Plan coverage by the County Board of Supervisors.

Benefit Payments

After you have satisfied a seven (7) consecutive calendar day waiting period, you are eligible to receive STD benefits. Generally, your Normal Weekly Benefit will be fifty-five percent (55%) of your Normal Weekly Earnings, not to exceed $728 per week for represented employees, or $1041 per week for Exempt employees. Benefits due for any partial weeks will be calculated at the daily amount of one-seventh (1/7) of the Normal Weekly Benefit. Your STD payments will be included in your biweekly pay warrant. In most cases this means your benefit payments will be automatically deposited into your bank account.

Normal Weekly Earnings are calculated as one-half (1/2) of the employee's average biweekly base salary. An employee's biweekly base salary is determined by averaging the amount earned through regular and paid leave time in the six (6) pay periods immediately preceding the commencement of the disability.

The date used to determine the maximum Normal Weekly Benefit that you are entitled to receive shall be the first date of the onset of your disability for which plan benefits are payable. The first date of the onset of your disability must be evidenced by a physician's statement, included in the STD Claim Packet. Failure to file a timely claim will not result in a higher Normal Weekly Benefit even if you received a salary increase between your first day of disability and the date your claim is filed.

The maximum benefit amount an employee covered by the Represented STD Plan may receive for any one (1) disability claim is fifty-two (52) times the Normal Weekly Benefit. Exempt employees may receive a maximum benefit amount of eighty-three (83) times the

daily benefit amount. An Extended Maximum Benefit Amount of up to twenty-six (26) times the Normal Weekly Benefit may be available to Exempt employees who are returned to Transitional Work due to the disability.

Coordination and Reduction of Benefits

Normal Weekly Benefit payments will be coordinated so that the total weekly payments from this Plan and payments the employee may be entitled to receive from any one (1) or all of the following does not exceed 100% of the employee's Normal Weekly Earnings: 1) Earnings (salary) received while participating in transitional work; 2) Earnings (salary) received for actual days worked during any partial week of disability or from any form of paid leave time; or 3) Periodic payments received from the San Bernardino County Employees' Retirement Association.

Normal Weekly Benefit payments will be reduced by the amount that an employee receives or is entitled to receive from any of the following, by reason of the disability for which Plan Benefits are sought: 1) The Social Security Act, including dependents' benefits; 2) The Railroad Retirement Act, including dependents' benefits; 3) Any group plan available through and paid by a County recognized labor management trustee, union, or other County employee benefit plan; or 4) Any periodic payments the employee is entitled to apply for and receive with respect to SDI.

Transitional Work

Transitional Work means temporary changes to an employee's Regular and Customary Work in an effort to accommodate temporary restrictions placed on the employee by the treating physician and approved by the Center for Employee Health and Wellness and Employee Health and Productivity (EHaP) Program.

Employees are required, as a condition of participation in this Plan, to actively cooperate with the efforts of the EHaP Nurse Care Coordinators in recovering from their disability. If an employee returns to work part-time through Transitional Work and suffers a partial wage loss, Plan Benefits may continue up to their Normal Weekly Earnings, limited to the Normal Weekly Benefit. Under no circumstances will an employee be entitled to receive more than 100% of their Normal Weekly Earnings when their part-time weekly salary and Plan Benefit payments are added together.

Integration of Benefits

Plan Benefit payments may be fully or partially integrated with other paid time including, but not limited to, sick leave, vacation leave, holiday leave, and regular work hours. Employees may not receive more than 100% of their Normal Weekly Earnings. Employees who have at least 41 hours of accrued leave in their bank and elect to fully integrate Plan Benefit payments with other paid time will receive all benefits and accruals as if they were receiving full regular pay. If an employee elects not to fully integrate, or is not eligible to fully integrate, only paid time recorded will be attributable toward benefits and accruals. Employees may also elect not to integrate any other paid time with Plan Benefits. Plan Benefit payments shall not count toward any benefits or accruals for employees who elect partial or no integration. All benefits and accruals will be administered in accordance with the applicable MOU, contract, or salary ordinance pertaining to the employee.

Filing a Claim

To file a claim for Plan benefits, you must complete and submit an STD Claim Packet,

which includes a Claim for Short-Term Disability Benefits (3 parts – Employer's Statement, Claimant's Statement, and Physician's Statement), an EHaP Release of Medical Information for STD, and a Leave Integration Request. You can obtain an STD Claim Packet from your department payroll clerk or download the forms from the intranet at http://countyline/emacs/forms.asp. No Plan Benefits will be paid until all completed forms have been received by the claims administrator listed on the claim forms. Failure to furnish completed forms within the first ninety (90) days of the disability period may result in the loss of benefits.

Exclusions

You will not be eligible to receive benefits for any disability directly or indirectly due to or resulting from any one or more of the following:

- Self-inflicted injury while sane or insane.
- War, insurrection or hostilities of any kind, whether or not you were a participant in such action.
- Participation in any riot or civil commotion.
- Commission or attempt to commit a felony.
- Confinement by court order or certification as a dipsomaniac, drug addict, or sexual psychopath.
- Cosmetic surgery or other services for beautification.
- Weight reduction or treatment of obesity, except for the treatment of morbid obesity.
- Procedures or treatments to change characteristics of the body to those of the opposite sex or the reversal thereof.
- Disabilities caused by the actions of another person or a third party unless you and/or your legally authorized representative, lawyer, and/or agent furnish the Plan Administrator a signed agreement that legally obligates you or your representative(s) to refund monies paid to you under the Plan. Refunded monies are limited to the extent that you or your legally authorized representative, lawyer, and/or agent recovers from the third party that was responsible for your Disability.

In addition to the exclusions listed above, STD benefits will not be paid under any of the following circumstances:

- During any period that you are entitled to receive State Unemployment Insurance.
- If you have involuntarily terminated County employment prior to becoming disabled or at any time that you voluntarily terminate your County employment.
- When you engage in any gainful occupation on a partial, part-time or full-time basis that is inconsistent with your disability.
- While you are incarcerated due to conviction of a crime.
- During any period of disability when you are not under the care of a Physician. In the case of disability due to mental disorder, STD benefits will not be paid for any period of disability during which you are not under the continuing care of a specialist in psychiatry or psychology.
- If you are eligible for or receiving SDI benefits in an amount greater than your STD benefit.

NOTE: This is only a summary and partial listing of STD Plan benefits, terms, conditions, exclusions and limitations. For a full and complete listing, please refer to the STD Plan Document. If any differences appear between this summary and the STD Plan Document, the information in the STD Plan Document shall govern.

For any questions or additional information regarding Short-Term Disability, contact Employee Benefits and Services, Hospitality at (909) 386-8600, or go on-line to www.sbcounty.gov/hr/benefits or http://countyline/hr/benefits

Life Insurance

Life insurance provides your beneficiaries with valuable financial protection if you die. Eligible employees may purchase additional life insurance in two ways: 1) through the Voluntary Term Life Insurance Plan, and 2) through the Variable Universal Life (VUL) Insurance Plan. Participation in either plan is voluntary.

Voluntary Term Life

Eligibility

Your Memorandum of Understanding (MOU), Exempt Compensation Plan, salary ordinance, or your contract governs eligibility for Voluntary Term Life Insurance. Employees in the occupational units listed below are eligible (dependent coverage is not available under the Voluntary Term Life Insurance Plan):

- Administrative Services
- Attorneys
- Clerical
- Contract (depending on contract)
- Craft, Labor & Trades
- Elected Officials
- Exempt Employees
- Management
- Professional
- Safety
- Safety Management & Supervisory
- Specialized Peace Officers
- Specialized Peace Officers - Supervisory
- Supervisory
- Technical & Inspection

Before you may enroll in the plan or make changes to your elections during the annual Open Enrollment, you must:

- Be in an eligible position (see list)
- Work 41 hours or more per pay period

(You are NOT eligible to enroll or make changes if you are on a leave of absence)

- Complete 1040 hours of satisfactory performance (160 hours for Attorneys and 13 pay periods for Safety, Safety Management & Supervisory).

Once you have met the eligibility requirements, you may enroll initially within 30 days of becoming eligible, or you may wait and enroll during Open Enrollment. After your initial enrollment, you may make changes in coverage only during Open Enrollment.

Plan Options If you are eligible to participate in the plan, you may choose coverage equal to one, two, three, four or five times your base annual salary. Base annual salary for this coverage is your biweekly rate of pay (i.e.,

Biweekly Cost Schedule

Your Age	Biweekly Premium Cost Per $1,000 Of Coverage*
Under 30	$0.03
30 but less than 35	$0.04
35 but less than 40	$0.05
40 but less than 45	$0.07
45 but less than 50	$0.11
50 but less than 55	$0.18
55 but less than 60	$0.28
60 but less than 65	$0.42
65 and over**	$0.65

*Effective pay period 16 (warrant received August 5, 2004.)

**The Voluntary Term Life Insurance coverage amount will be reduced on the date an employee reaches 65, 70 and 75. For employees who enroll and who have already reached age 65, the reduction becomes effective on the Voluntary Term Life Insurance effective date. Reduction amounts are available in the Voluntary Term Life Insurance booklet that is available from your payroll clerk.

your hourly rate times the number of hours scheduled to work) multiplied by 26 pay periods. This number is then rounded up to the nearest thousand dollars.

Your base annual salary is then multiplied by one, two, three, four or five depending upon the coverage you elect. Coverage of up to $250,000 (County paid, plus Voluntary Term Life) is guaranteed and the insurance company will not require evidence of good health or a physical exam to participate in this plan. If you elect more than $250,000 coverage, you will be required to provide evidence of good health to the insurance company. Evidence of good health may include questionnaires, physical exams or written documentation required by the insurance company. If you are denied coverage above $250,000, your Voluntary Term Life, plus County paid Life Insurance amount, will be limited to $250,000.

Beneficiary for Voluntary Term Life Insurance Benefits will be paid automatically to your beneficiary in the following order: (1) surviving spouse, (2) surviving children, (3) your parents, (4) brothers and sisters, (5) estate. If more than one beneficiary becomes entitled to your benefits, they will share equally. To change the automatic beneficiary arrangement, you must complete the Voluntary Term Life Insurance Beneficiary Designation/Change section of eBenefits (during the Open Enrollment period only) or through your Payroll Clerk.

Initial Enrollment New employees may enroll within 30 days of the date they complete the required hours for their occupational unit. If you are a new employee and you do not enroll within the specified 30-day enrollment period, you will be eligible to enroll during the next Open Enrollment.

Payroll Deductions and Effective Date of Coverage Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium. For the 2004 Open Enrollment, premium collection begins with pay period 16, the pay warrant received on or about August 5, 2004. Coverage is effective July 24, 2004. If you have requested coverage above $250,000, your coverage date is subject to insurance company approval. After the County receives the insurance company's approval of your application, coverage will begin the first day of the pay period following the date the County receives your premium.

Life insurance helps provide your beneficiaries with financial protection if you die. Thinking about life insurance needs is not generally foremost in your mind. But, when a major event changes your life, your life insurance coverage might need to change as well.

Waiver of Premium While Disabled The Waiver of Premium benefit is a safeguard against losing your life insurance in the event of financial hardship caused by a disability. If you are unable to engage in any occupation for profit or gain, as determined by the insurance company, you will continue to have coverage without further premium payments provided the disability occurred while covered by the plan and before age 65. The insurance company requires proof of disability within 12 months of the date total disability begins and once each year so long as the disability continues. The benefit amount continued is subject to reduction at age 70.

For more information about VUL and/or to enroll in the VUL plan, you must call AGB at (866) 956-1876 and speak with an AGB representative.

If you return to work for the County and want to continue coverage, you must contact your payroll clerk or Employee Benefits and Services at (909) 387-9675 within 30 days of your return-to-work date. If your disability ends but you do not return to work for the County, you may convert the County's group plan under the same terms as a terminating County employee.

Living Benefits Option When an employee is coping with a terminal illness, the Living Benefits Option pays a portion of the benefit now, with unrestricted use, and pays the remainder as a death benefit later. The request cannot exceed 80% of the value of your life insurance policy, and is subject to a minimum of $3,000 and a maximum of $500,000.

Termination of Coverage Your Voluntary Term Life Insurance coverage will terminate if:

- You cancel your coverage
- You cease to be an eligible employee
- You fail to pay your required premiums when due
- The master contract is terminated
- You are on an approved leave of absence for more than 12 months

Conversion to an Individual Policy You may convert your Voluntary Term Life coverage from the County's group policy to an individual policy if:

- You cease to be an employee of the County and the master contract is still in effect
- The master contract terminates and you have been insured for at least five years
- Loss of coverage due to age reductions
- You are on an approved leave of absence for more than 12 months

Important: If your group life coverage ends, you have 31 days to convert to an individual policy with Hartford Life, without having to complete a Personal Health Statement to show proof of good health. Please contact Hartford at 1-877-ONE-HART.

How To Get In Touch With The Voluntary Term Life Insurance Plan

For questions about plan design, claim status/payments, medical underwriting and eligibility, call The Hartford at 1-877-ONE-HART. For questions about enrollment, current coverage or to request claim paperwork, call Employee Benefits and Services at (909) 387-9675.

Variable Universal Life

Pacific Life and Annuity underwrites the Variable Universal Life (VUL) Insurance Plan. Strategic Capital Management (SCM) is the consulting firm who will provide investment counseling for participants in the VUL Plan. Variable Universal Life Insurance differs from Voluntary Term Life Insurance coverage in that a portion of the premiums is placed into an investment account. Money in the investment account is used to offset insurance cost increases due to aging. VUL offers two different options: the Level Premium Option and the Step Premium Option. The premiums for the Level Premium Option are initially higher. The reason for this is that more money is put into the investment account to maintain a level premium. The Step Premium Option premiums are similar to the Voluntary Term Life Plan and increase every five years, as do the Voluntary Term Life premiums. The Step Premium Option also offers a Fixed LT Account. The current rate for this account is 6.9%. Some of the benefits of both options include:

- Cash-value growth.
- Tax-free death benefits and tax-deferred growth.
- Withdrawal and loan privileges.
- Portability (you may take your policy with you if you leave County employment).

Eligibility

Eligibility for VUL is governed by your Memorandum of Understanding (MOU), Exempt Compensation Plan, salary ordinance, or contract. Employees in the occupational units listed below are eligible (dependent coverage is not available under the Variable Universal Life Insurance Plan) to enroll:

- Administrative Services
- Clerical
- Contract (depending on contract)
- Craft, Labor & Trades
- Elected Officials
- Exempt Employees
- Management
- Professional
- Supervisory
- Technical & Inspection
- Units represented by SBPEA

Note: Safety employees and firefighters are not eligible for this benefit.

Before you may enroll in the plan or make changes to your elections during a future Open Enrollment, you must:

- Be in an eligible position (see the above list)
- Work 41 hours or more per pay period

New employees may enroll, once they have met the eligibility requirements, within 30 days of becoming eligible, or wait and enroll during an Open Enrollment. After you first enroll, you may only make changes in coverage during Open Enrollment. If you do not enroll during this Open Enrollment, you may enroll during a future Open Enrollment; however, the insurance company may require a health questionnaire and a physical exam.

Payroll Deductions and Effective Date of Coverage The premiums for this policy are based upon individual factors, such as base rate of pay, age, and smoking status. To obtain a personal illustration of premium cost, you must call or meet with an AGB registered representative. Please call AGB at 1-866-956-1876 for information or to set up an appointment. Once you have met with an AGB representative and your premiums are established, AGB will notify the County of your premium deduction. Deductions are taken from the first and second pay warrant of the month, 24 times a year. Premiums are collected a month in advance of the coverage month. For the 2004/2005 Open Enrollment, most premium deductions will begin July 24 and coverage will be effective August 21, 2004.

County Contribution The employee pays the cost of this benefit. However, if you are an elected official or an Exempt employee and you elect to purchase VUL insurance, the County will contribute toward your biweekly premium based upon your Benefit Group:

- Elected Officials and Benefit Group A: 100% of the one-time base annual salary earnings option.
- Benefit Group B: 50% of the one-time base annual salary earnings option.
- Benefit Group C: 25% of the one-time base annual salary earnings option.

Beneficiary for Variable Universal Life Insurance You must designate a beneficiary at the time of enrollment. Benefits will be paid according to your instructions. If your beneficiary dies before you, the benefits will be paid to your estate.

How To Enroll

To enroll in the VUL Plan, you must speak or meet with a registered AGB representative. The AGB registered representative will explain the plan, its benefits and features, and answer your questions. Also, the AGB representative will explain your investment choices and give you the information and paperwork you need to enroll. To arrange for your personal and confidential consultation, call 1-866-956-1876.

To provide you and your family with additional financial protection, the County offers you Accidental Death and Dismemberment (AD&D) Insurance.

AD&D coverage provides a benefit if you or a covered dependent loses a limb, loses eyesight or dies as the result of an accident.

Accidental Death & Dismemberment (AD&D)

Employee Eligibility

Employees in the occupational units listed below may enroll within 30 days of completing 1040 hours (160 hours for Attorneys) of satisfactory employment. If you do not enroll at that time, your next opportunity to enroll is during the Open Enrollment period. You may make changes in your AD&D coverage during Open Enrollment.

- Administrative Services
- Attorneys
- Clerical
- Contract (depending on contract)
- Craft, Labor & Trades
- Elected Officials
- Exempt Employees
- Management
- Professional
- Specialized Peace Officers
- Specialized Peace Officers - Supervisory
- Supervisory
- Technical & Inspection

Eligible Dependents for AD&D Coverage

- Spouse
- Registered Domestic Partner (effective December 25, 2004)
- Unmarried children (including legally adopted children) who are under age 19 and who are dependent upon you for support, or who are at least 19 but less than 23 who are students and dependent upon you for support.

If you choose dependent coverage, all of your eligible dependents will be enrolled. However, to enroll your dependent(s), you must be enrolled yourself.

Note: Safety employees and firefighters are not eligible for this benefit.

Plan and Coverage Options

You have four coverage options and seven AD&D plans from which to choose:

Coverage Options

1 Employee-only coverage: Coverage will be the amounts listed in the Employee column on the Plan Options Table below for each of the seven plans.

Employee plus dependent coverage is governed by the type of dependents you have, such as:

2 Employee plus Spouse or Domestic Partner [no child(ren)]: Coverage amounts will be the amounts listed in the Employee column and the Spouse or Domestic Partner column below for each of the seven plans.

3 Employee plus child(ren) (no spouse): Coverage amounts will be the amounts listed in the Employee column and the Each Child column below for each of the seven plans.

4 Employee plus family: Coverage amounts will be the amounts listed in the Employee column, the Spouse or Domestic Partner column and Each Child column below for each of the seven plans.

Plan Options Table

Plan	Employee	Spouse or Domestic Partner	Each Child
1	$ 10,000	$ 5,000	$ 3,125
2	25,000	12,500	6,250
3	50,000	25,000	12,500
4	100,000	50,000	25,000
5	150,000	75,000	25,000
6	200,000	100,000	25,000
7	250,000	125,000	25,000

Benefits The plan will pay the following benefit for the loss of:

Life	The Principal Sum
Both Hands or Both Feet or Sight of Both Eyes	The Principal Sum
One Hand and One Foot	The Principal Sum
Speech and Hearing	The Principal Sum
Either Hand or Foot and Sight in One Eye	The Principal Sum
Movement of Both Upper and Lower Limbs (Quadriplegia)	The Principal Sum
Movement of Both Lower Limbs (Paraplegia)	Three-Quarters The Principal Sum
Movement of Both Upper and Lower Limbs of One Side of the Body (Hemiplegia)	One-Half The Principal Sum
Either Hand or Foot	One-Half The Principal Sum
Sight of One Eye	One-Half The Principal Sum
Speech or Hearing	One-Half The Principal Sum
Thumb and Index Finger of Either Hand	One-Quarter The Principal Sum

Benefits are limited to the full benefit for losses from one accident.

If you marry after enrolling for AD&D coverage, you may add your new spouse by submitting new enrollment and payroll deduction authorization forms within 30 days of the date of marriage. Once family coverage is in force, all newly eligible dependents (such as a newborn) are enrolled automatically.

Beneficiary for AD&D

Insurance benefits will be automatically paid to your beneficiary in the following order: (1) surviving spouse, (2) surviving children, (3) your parents, (4) brothers and sisters, (5) estate. If more than one beneficiary becomes entitled to your benefits, they will share equally.

Initial Enrollment

New employees may enroll within 30 days of the date they complete 1040 hours of satisfactory performance (160 hours for attorneys). If you are a new employee and you do not enroll within the specified 30-day enrollment period, you will be eligible to enroll during the next Open Enrollment period.

Payroll Deductions and Effective Date of Coverage Once you enroll, you will be covered on the first day of the pay period following the date the County receives your premium. For the 2004/2005 Open Enrollment, premium collection begins with pay period 16, the pay warrant received on or about August 5, 2004. Coverage is effective July 24, 2004. Before-tax payroll deductions for AD&D premiums are available to employees through their Benefit Plan Premium Conversion Option.

Premium Table

Plan	Employee Only Coverage	Family Coverage	Employee and Spouse or Domestic Partner Coverage	Employee and Child Coverage
1	$ .14/pay period	$ .17/pay period	$ .15/pay period	$ .15/pay period
2	$ .35/pay period	$ .43/pay period	$ .38/pay period	$ .38/pay period
3	$ .70/pay period	$ .85/pay period	$ .75/pay period	$ .75/pay period
4	$ 1.40/pay period	$ 1.70/pay period	$ 1.50/pay period	$ 1.50/pay period
5	$ 2.10/pay period	$ 2.55/pay period	$ 2.25/pay period	$ 2.25/pay period
6	$ 2.80/pay period	$ 3.40/pay period	$ 3.00/pay period	$ 3.00/pay period
7	$ 3.50/pay period	$ 4.25/pay period	$ 3.75/pay period	$ 3.75/pay period

If before-tax dollars are used to pay the premiums, you may cancel the plan only when you have a Benefit Plan qualified change in status/life event.

Termination of Coverage

Your AD&D coverage will terminate if:

- You cancel your coverage
- You cease to be an eligible employee
- You fail to pay your required premiums when due
- The master contract is terminated
- You are on an approved leave of absence for more than 12 months

Conversion to an Individual Policy

You may convert your AD&D coverage from the County's group policy to an individual policy if:

- You cease to be an eligible employee and the master contract is still in effect
- You have not failed to pay any premium
- Loss of coverage due to age reductions
- You are on an approved leave of absence for more than 12 months

Important: If your group coverage ends, you have 31 days to convert to an individual policy with Hartford Life, without giving medical evidence of insurability, to cover yourself and your eligible dependents who are covered under the policy on the date your coverage ceases.

How To Get In Touch With An AD&D Representative

For questions about plan design, claim status/ payments, medical underwriting and eligibility, call The Hartford at 1-877-ONE-HART. For questions about enrollment, current coverage or to request claim paperwork, call Employee Benefits and Services at (909) 387-9675.

Employee Assistance Program (EAP) CIGNA Behavioral Health

The County provides an Employee Assistance Program (EAP) for all employees, their dependents and members of their households through **CIGNA Behavioral Health**. The EAP offers services designed to help employees reduce stress, balance their work and family responsibilities, and improve the quality of their lives.

The program offers resource and referral services, counseling and support services, online information and interactive tools.

The clinical EAP services can help with problems such as:

- Alcohol and drug abuse
- Crisis situations
- Emotional difficulties
- Family conflicts
- Financial problems
- Grief issues
- Marital conflicts
- Stress
- And many more!

CIGNA also provides work/life EAP services that offer answers, information and support for many of the questions and issues people face in their day-to-day lives. Some work/life issues include:

Child Care Infertility, adoption, daycare, nutrition, child development and more

Senior Care Care options, nursing homes, health and diet issues, Alzheimer's and more

Financial Information Spending habits, budgeting strategies, managing credit and more

Healthy Rewards® Referrals and discounts on chiropractic care, acupuncture, massage therapy, vitamins and more

Pet Care Pet-sitting resources, obedience training, veterinarians and more

Legal Services Wills, leases, family law, bankruptcy and more

How Much Does it Cost?

EAP services are **free**. Employees, dependents and household members are provided with up to three (3) face-to-face, one-on-one, or group family counseling sessions per problem area each year at no cost. If further services are required beyond the free sessions, every effort will be made to help the client access appropriate care through their health plan, or through community or private resources.

Who Will Know?

EAP services are **confidentia**l. Privacy is guaranteed under the law when an employee self refers. Therefore, no information will be released without the written consent of the employee.

How to Access the EAP

The clinical and work/life EAP services are accessible 24 hours a day, 365 days a year by:

- Calling toll free **1-888-241-7668.**

— or —

- Logging on to www.cignabehavioral.com.
  1. Select Log in link
  2. For Employer ID, type "countyofsanbernardino" using lowercase letters with no spaces
  3. For PIN, type "employee"
  4. Select the Education and Resource Center

For further information regarding the EAP, please contact the Employee Health and Productivity (EHaP) Program's Wellness Coordinator at 909-386-5138.

24-Hour Fitness

County employees are eligible for a 24-Hour Fitness membership. The standard "Keep Fit" membership is good at over 140 standard club locations, during all club hours, excluding sports clubs. The Sport "Keep Fit" membership is good at all Sport and Standard 24-Hour Fitness Clubs. Baby-sitting is available at most centers for a nominal fee.

This program is part of the County's campaign to help you stay well and maintain a healthier lifestyle. As part of its commitment to your health and well-being, the County has paid your initiation fee and negotiated the following discounted monthly membership dues:

Monthly Dues

	Initiation*	Standard Club	Sport Club
Employee only	$ 0	$16	$24
Employee plus one family member	$30	$23	$31
Employee plus two family members	$50	$29	$39
Each additional family member	$ 0	$10	$10

For Lake Shore Towers in Irvine, call 1-909-381-7943 for information about an additional initiation fee and monthly dues.

These special rates are available to County employees only during Open Enrollment. Family members must be related as spouse or child (12-22 years of age, unmarried) and living at the same address. Employees must provide proof of County employment. 24-Hour Fitness will accept County ID; Leave and Earnings Statements; business card; or a letter from the Human Resources Department, Employee Health and Productivity (EHaP) Program as proof of County employment.

The most important feature of balanced fitness is to be consistent.

A regular program of aerobics, strengthening and stretching exercises will help you feel and look fantastic!

Employees may enroll at any 24-Hour Fitness club location. New hires: you have 60 days from your hire date to enroll. No other discounts may be used in conjunction with this offer. County employees who already have a 24-Hour Fitness membership are also eligible to have their monthly dues reduced to the County's rate during this time frame.

Upon initial enrollment, employees will be responsible for rendering payment for their first and last months' dues in addition to any applicable initiation fee. Monthly dues are paid by electronic fund transfer (EFT) directly from your checking or savings account. You may also authorize monthly payment by Visa, MasterCard, American Express, or Discover credit cards. Payroll deduction is not available. Employees may cancel their membership at any time without penalty.

For any questions or additional information regarding 24-Hour Fitness contact your department payroll clerk or go on-line to www.sbcounty.gov/hr/ehap/24_hr_fitness or http://countyline/hr//ehap/24_hr_fitness

24-Hour Fitness Representatives

Cathedral City	Tania Camp	(760) 324-0504
Corona	Kevin Long	(909) 734-0121
Fontana	Johnny Butler	(909) 357-8000
Moreno Valley	Don Tan	(909) 653-7100
Rancho Cucamonga	Alex Sotolongo	(909) 944-1000
Redlands	E.J. Carter	(909) 798-7777
Riverside	Bob Balmer	(909) 360-1696
San Bernardino	Mike Doucette	(909) 370-1111
Victorville	Shane Haffey	(909) 357-8000

For any club not listed or to obtain additional membership information, please call the corporate manager, Carol Wiltgen, at (909) 224-5854.

Retirement Plan Highlights

Eligibility

All employees working at least 40 hours per pay period in a retirement eligible position are automatically members of the San Bernardino County Employees' Retirement Association (SBCERA). As a member of SBCERA, you make contributions each pay period for your retirement and survivor benefits by payroll deduction. There will be a change to your required retirement contribution and the premiums for survivor benefits effective June 26, 2004. The survivor benefit premiums will increase from $2.01 to $2.20 per pay period. The Contribution Rate Table below details the new rates for both General and Safety employees.

Employee Retirement Contribution Rate Table

General Employees Contribution Rate (%)		Safety Employees Contribution Rate (%)	
Entry Age	**2004**	**Entry Age**	**2004**
15	8.37	15	10.23
16	8.37	16	10.23
17	8.37	17	10.23
18	8.37	18	10.23
19	8.37	19	10.23
20	8.37	20	10.23
21	8.39	21	10.23
22	8.43	22	10.26
23	8.47	23	10.30
24	8.52	24	10.35
25	8.58	25	10.41
26	8.64	26	10.49
27	8.71	27	10.57
28	8.79	28	10.67
29	8.88	29	10.77
30	8.97	30	10.89
31	9.07	31	11.01
32	9.18	32	11.14
33	9.29	33	11.28
34	9.40	34	11.44
35	9.52	35	11.60
36	9.64	36	11.76
37	9.76	37	11.94
38	9.89	38	12.12
39	10.02	39	12.30
40	10.15	40	12.48
41	10.28	41	12.67
42	10.42	42	12.86
43	10.56	43	13.05
44	10.71	44	13.24
45	10.86	45	13.44
46	11.00	46	13.63
47	11.16	47	13.83
48	11.31	48	14.03
49	11.47	49 & over	14.24
50	11.63		
51	11.79		
52	11.95		
53	12.12		
54 & over	12.28		

The easiest way to determine your retirement obligation is to look at your Leave and Earnings Statement for your earnable compensation. Determine your contribution rate from the neighboring table. Subtract 7% to account for the County "pick-up." Your earnable compensation, multiplied by this resulting percentage, is your retirement obligation.

Note: Cash benefits* might change from pay period to pay period, so your retirement obligation could fluctuate.

[(_____ x _____) + _____] X [_____ - 7.0%] = _____

Wage Rate **Scheduled Hours** **Cash Benefits*** **Contribution Rate** **Retirement Obligation**

* A 1997 California Supreme Court decision, Ventura County Deputy Sheriff's Association vs. Board of Retirement of Ventura County Employees' Retirement Association, requires many benefits received in cash to be added to your compensation for determining your retirement contributions. Cash benefits include, but are not limited to, your biweekly benefit plan, uniform and tool allowances, bilingual pay, and many types of pay differentials. ***Note:*** Overtime is not a cash benefit as defined by the Ventura Ruling.

For example*: the biweekly retirement contribution for a general member with an entry age of 43, earning $10.05 per hour, receiving a biweekly benefit plan of $190.00 and $40.00 per pay period in bilingual pay is calculated as:*

[($10.05 x 80 hours) + $230.00] x [10.56% - 7.0%] = $36.81 obligation per pay period

Refundable and Nonrefundable Retirement Options

You may change your retirement options each year during Open Enrollment. If you wish to change your retirement options, you must complete the *Retirement System Contribution Election* section of eBenefits. Elections will be effective pay period 17 and you will see the election change on the pay warrant you will receive on or about August 5, 2004.

Refundable Retirement Contributions If you designate your retirement contributions as refundable, then you must pay one dollar for each dollar required to meet your retirement contribution. If you leave employment without retiring, you may withdraw this contribution plus earned interest in one lump sum from the SBCERA.

Nonrefundable Retirement Contributions If you designate your retirement contributions as nonrefundable, your retirement obligation will be reduced for each dollar required to meet your retirement contribution. This reduction is determined by the Board of Retirement annually and is subject to change. There is a change for the 2004/2005 Plan Year. General employees will pay $1.00 for every $1.12 required to satisfy their retirement obligation; Safety employees will pay $1.00 for every $1.05 required. If you leave the County without retiring, you may not withdraw this contribution from the SBCERA. When, and if, you are eligible you may receive a retirement benefit.

Refundable vs. Nonrefundable Table

The following table outlines some of the advantages and disadvantages of choosing between the refundable and nonrefundable retirement options. Generally, if you have less than five (5) years of full-time service, it may be beneficial to choose the refundable option.

EVENT	REFUNDABLE OPTION	NONREFUNDABLE OPTION
Employee's biweekly cost	Safety and General employees contribute $1.00 for every $1.00 required.	General employees contribute $1.00 for every $1.12 required; Safety employees contribute $1.00 for every $1.05 required.
Termination before five (5) years of County employment completed	All employee and employer contributions made on your behalf that were paid under the refundable option will either, if elected, be refunded to you in a lump sum with interest; or, you may choose to leave said funds "on-deposit" with the retirement system to earn the applicable member deposit interest rate as determined by the Board of Retirement.	None of the employee and employer contributions made on your behalf that were paid under the nonrefundable option will be paid in a lump sum. Note: employees with contributions under both the refundable and nonrefundable options will be refunded only the contributions that were designated as refundable.
Termination after five (5) years of County employment	The employee has the option of deferred retirement or receiving a lump sum refund of employee and completed employer contributions made on your behalf with interest.	Deferred retirement OR refund of refundable contributions, if any exist.
Nonservice-related death before five (5) years of County employment	Spouse or dependent children receive return of employee contributions, interest and one month's salary for each completed year of service, up to a maximum of six months' salary; survivor benefits are available if general member worked at least 18 months.	Spouse or dependent children receive one month's salary for each completed year of service, up to a maximum of six months' salary; survivor benefits are available if general member worked at least 18 months.
Nonservice related death after five (5) years of County employment	Option 1 Eligible spouse or dependent children receive 60% of the amount awarded in a nonservice-connected disability retirement. Option 2 Lump sum payment of one month's salary for each completed year of service for a maximum of six months; plus a monthly amount actuarially reduced according to the age of the beneficiary.	Option 1 Eligible spouse or dependent children receive 60% of the amount awarded in a nonservice-connected disability retirement. Option 2 Lump sum payment of one month's salary for each completed year of service for a maximum of six months; plus a monthly amount actuarially reduced according to the age of the beneficiary.

Refundable vs. Nonrefundable Table *(continued)*

EVENT	REFUNDABLE OPTION	NONREFUNDABLE OPTION
	Option 3 If there is no spouse or eligible child, the beneficiary will be entitled to one month's salary for each completed year of service, up to a maximum of six months, plus the return of the member's accumulated contributions plus interest; spouse may also choose this option.	Option 3 If there is no spouse or eligible child, the beneficiary will be entitled to one month's salary for each completed year of service, up to a maximum of six months, plus the return of the employee's refundable contributions plus interest, should any exist; spouse may also choose this option.
Service-related death before retirement	Option 1 Eligible spouse or dependent children receive 100% of the amount awarded in a service-connected disability retirement; Safety employee's spouse or dependents may receive an additional payment. Option 2 Same as previous page. Option 3 Same as above.	Option 1 Eligible spouse or dependent children receive 100% of the amount awarded in a service-connected disability retirement; Safety employee's spouse or dependents may receive an additional payment. Option 2 Same as previous page. Option 3 Same as above.

The information contained in the Refundable vs. Nonrefundable Table is a summary of information provided by SBCERA.

How to Get in Touch with a Representative of the Retirement Plan

For more information about the retirement plan, please refer to the Retirement Plan Booklet or call the San Bernardino County Employees' Retirement Association at (909) 885-7980, or toll free at 1-877-722-3721.

Questions and Answers

1 I am covered as a dependent under my spouse's medical and dental plans. Must I also enroll in one of the County's medical and dental plans?

All County employee are required to enroll in a County-sponsored medical and dental plan. However, there are two exceptions to this rule.

a. Waive to County Spouse. If your spouse is an employee of the County of San Bernardino and is enrolled in a County health and/or dental plan and enrolls you as a dependent on his/her plan, that enrollment satisfies the County requirement. The following conditions apply to a County employee married to another County employee:

- At the time of enrollment, you or your spouse may elect to waive individual coverage; however, the spouse who waives coverage must be enrolled under the other spouse's medical and dental plans.
- If you are married to another County employee and you and your spouse are covered under separate County medical and dental plans, you or your spouse may waive coverage and enroll as a dependent on your spouse's medical and dental plans during the County's Open Enrollment.
- If you marry another County employee during the year, you may waive your coverage and enroll as a dependent on your spouse's medical and dental plans within 30 days of your marriage.

b. Opt-Out to Other Employer-Sponsored Group Health or Dental Plan. If you are enrolled, or become eligible to be enrolled due to a qualifying event, in your spouse's employer's comparable group medical and/or dental plan, you may choose to Opt-Out

of the County plan. You must complete the required Opt-Out forms and submit them along with proof of other plan coverage to Employee Benefits and Services within thirty (30) days of the effective date of the other group coverage. You may also Opt-Out during the County's Open Enrollment period as long as the required documents are submitted during the applicable Open Enrollment period. For specific information regarding Opt-Out guidelines, eligibility or to receive an Opt-Out form, please go to the Employee Benefits Web site at www.co.san-bernardino.ca.us/hr/benefits or contact Employee Benefits and Services at (909) 387-5787.

See your payroll clerk for more information and to obtain the required enrollment, waiver and/or Opt-Out forms.

2 When does a covered dependent lose eligibility?

A covered dependent loses eligibility on the last day of the pay period during which:

- You become ineligible to receive County benefits
- Your child, between the ages of 19 and 24, ceases classification as a full-time student; coverage will continue during scheduled school break periods
- Your child attains age 24, regardless of student status; an exception is made for a disabled adult child with proper proof of disability
- Your child marries
- Your child ceases to be a dependent according to IRS regulations
- The final decree of divorce is granted (for spouse coverage)

You are responsible for notifying the County, within 30 days, of the dependent losing eligibility for coverage.

Note: Once a formal decree of divorce is granted, your former spouse must be deleted from your medical and/or dental plan coverage even if the divorce settlement requires you to provide coverage. Your ex-spouse will be eligible to continue coverage through COBRA if you provide notice of your divorce within 60 days of the event date. See COBRA information in question 8 of this section for more information.

3 Do I have to notify anyone when a dependent becomes ineligible for coverage?

Yes. It is your responsibility to complete a *Benefits Election Agreement* and submit it to your payroll clerk within 30 days of the date a dependent loses eligibility. If you fail to notify the County within 30 days, you might be liable for any claims paid or services rendered on behalf of an ineligible family member.

Your notification within 30 days is very important. The County's agreements, plan documents and administrative policies require the County to notify the plans within specified time frames. Employees who fail to notify the County within 30 days might experience a loss of premiums and/or loss of eligibility to delete dependents.

4 What happens to my coverage if I am on a leave without pay?

Check your Memorandum of Understanding (MOU), Exempt Compensation Plan, salary ordinance, or contract to determine what happens to your benefits when on an approved medical leave of absence. Once your County provided benefits and any applicable state or federal benefits (such as the Family Medical Leave Act, Pregnancy Disability Act or the California Family Rights Act) have been exhausted, you might be able to continue your health and welfare plan coverage through COBRA, a federal law that allows you to continue coverage at your own expense. Contact Employee Benefits and Services at (909) 387-5552 for more information.

5 Why would I receive a Statement of Premium Due?

Statements of Premium Due are sent when your insurance premiums were not collected from your pay warrant. A statement will also be sent whenever premiums are not collected prior to the effective date of coverage. Typically, this occurs when:

- You add a dependent, resulting in a higher premium.
- You have a reduction in hours worked or a leave of absence, resulting in insufficient pay for premiums or loss of Benefit Plan Dollars.

6 What happens to my medical and dental coverage when I retire?

When you retire, your County health and welfare plan coverage will continue for one pay period following the last pay period in which you code one-half plus 1 of your normally scheduled work hours. You may be eligible to continue your health and welfare plan coverage through COBRA. See question 8 in this section regarding your COBRA rights. A COBRA notice will be mailed to your home approximately two weeks after you receive your final County pay warrant to remind you of this option. Once you retire, COBRA allows you to continue your current health and welfare plan coverage for up to 18 months. You will be responsible for the full premium plus a 2% administrative fee. Most premium payments are made directly to the County of San Bernardino and are mailed to

Employee Benefits and Services, Human Resources Department. Kaiser Permanente and Health Net premium payments are made directly to those companies. Deductions from your retirement pay warrant for payment of COBRA premiums are not available at this time.

If you are eligible to receive County retirement pay, you also have the option of enrolling in one of the medical plans and the Delta Dental Plan provided by the Board of Retirement. To obtain retiree plan information, premium cost and premium subsidy information, contact the SBCERA directly at 1-909-885-7980. Premium payments for these plans will be deducted directly from your retirement pay warrant. Retiree health enrollment forms must be completed and returned within 30 days of your retirement. If you do not elect to enroll in a SBCERA health plan within 30 days of retirement, you must wait until the next Open Enrollment for retirees.

For dental coverage, you may also contact the San Bernardino County Public Employees Association (SBPEA). SBPEA offers dental coverage to ALL County retirees (including Safety employees) regardless of whether you are member of that association. SBPEA dental insurance premiums will be deducted directly from your retirement pay warrant.

7 What happens if my family members or I become eligible for federal Medicare?

Employees and/or their dependents who are over the age of 65 or are disabled may choose either a County-sponsored medical plan or Medicare. If you and/or your dependents are eligible for Medicare, yet choose to stay in a County plan, Medicare will pay benefits after the County's plan has paid. To help you decide, call the Social Security office to discuss Medicare Parts A and B coverages and premiums. You will need to provide the Social Security office with your planned retirement date, the date you (and your dependents, if applicable) will attain age 65, and (if applicable) any information from Medicare notifying you of eligibility based on your disability.

8 What happens to my coverage if my employment with the County ends?

The County of San Bernardino, as required under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), offers employees and their covered family members the opportunity to elect a temporary extension of coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage would otherwise end due to certain qualifying events.

Should an actual qualifying event occur in the future, the Employee Benefits and Services Division of the County's Human Resources Department will mail you additional information and the appropriate election notices at that time. The group health and welfare plans maintained by the County offer no greater COBRA rights than what the COBRA statute requires, and this summary should be construed accordingly.

Qualifying Events

If you are an employee of the County and are covered by the group health and welfare plans maintained by the County, you have the right to elect continuation coverage if you lose coverage under the plans due to any one of the following "qualifying events:"

- Termination of your employment (for reasons other than your gross misconduct).
- Reduction in the hours of your employment.

If you are the spouse of an employee and are covered by the group health and welfare plans maintained by the County, you have the right to elect continuation coverage if you lose coverage under the plans due to any of the following "qualifying events":

- The death of your spouse.
- A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the County.
- Divorce or legal separation from your spouse.
- Your spouse becomes entitled to Medicare benefits.

In the case of an employee's dependent child who is covered by the group health and welfare plans maintained by the County, he or she has the right to elect continuation coverage if group health coverage under the plans is lost due to any of the following "qualifying events:"

- The death of the employee parent.
- The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment with the County.

- The employee parent's divorce or legal separation.
- The employee parent becomes entitled to Medicare benefits.
- The dependent ceases to be a "dependent child" under the plans.

Notices and Election

Under the COBRA statute, you (the employee) or a family member has the responsibility to notify the Employee Benefits and Services Division of a divorce, legal separation or a child losing dependent status under the group health and welfare plans maintained by the County. This notification must be made within 60 days from whichever date is later: the date of the event or the date which health and welfare plan coverage would be lost under the terms of the applicable insurance contracts because of the event. If you or a family member fail to provide this notice to the Employee Benefits and Services Division during this 60-day notice period, then rights to continuation coverage will be forfeited.

COBRA RIGHTS AND OBLIGATIONS

Individual Election Rights and Eligibility

Each individual who was covered under the group health and welfare plans maintained by the County of San Bernardino on the day before the qualifying event is a "qualified beneficiary" and has independent election rights to continuation coverage. This means that each dependent who was covered can elect independently to continue coverage, even if the covered employee chooses not to continue coverage. However, continuation coverage is available to qualified beneficiaries subject to their continued eligibility. The Human Resources Division Chief, Employee Benefits and Services Division of the County of San Bernardino, or designee, reserves the right to verify eligibility status and terminate continuation coverage back to the original COBRA effective date if it is determined that an individual is ineligible or coverage

was obtained through a material misrepresentation of the facts.

Under the provisions of COBRA, each qualified beneficiary can elect to continue all health and welfare plan coverages or any combination of the coverages in which they were enrolled in the day before the event. For instance, a qualified beneficiary could elect to continue their group medical coverage and waive the continuation of their group dental coverage. The applicable premiums will vary depending upon the coverages elected. If you are covered by a region specific HMO and are moving outside of the HMO service area, additional rights may be available to you at the time of the event. Please call the Employee Benefits and Services Division for additional information. Once an election of continuation coverage is made, the coverages may change if modifications are made to the coverages provided to similarly situated non-COBRA plan participants or if an Open Enrollment period occurs. Once enrolled, if your marital status changes, if a covered dependent ceases to be eligible for coverage, or if the address of you or your spouse changes, you must notify the Employee Benefits and Services Division immediately.

No Coverage During Election Period

You will not be covered under the plan(s) during the election period. However, if a COBRA election is made as described in the *Notice of Right to Elect Continuation of Group Health and Welfare Plan (COBRA) Coverage* and all applicable premiums are paid as detailed in the following section, then your health and welfare plan coverages selected will be reactivated back to your loss of coverage date in accordance with federal law.

Premium Payments

***For all plans EXCEPT Kaiser Permanente and Health Net*:** If you elect to continue your health and welfare plan coverage, as a qualified beneficiary you are responsible for

the full applicable premium payment for the coverage selected, which will include a 2% administration fee. After your election form is received by the Employee Benefits and Services Division, you will be sent a Confirmation of Election with a premium payment schedule. No further statements or requests for payment will be sent.

The premium payment schedule will reflect that the premium due date for COBRA coverage is the twenty-fifth (25) day of the month prior to each monthly coverage period. A grace period of thirty (30) days is provided to ensure that premiums are received. If payment for a specific monthly period is not received within this thirty (30) day grace period, coverage will be retroactively cancelled back to the last date for which coverage was paid.

COBRA premium payments can be either hand-delivered or mailed. If hand-delivered, it must be delivered to the Employee Benefits and Services Division. If mailed, document the date the premium is sent and call Employee Benefits and Services within 10 days to ensure the premium was received. If premiums are not received or, if mailed, not postmarked within the required premium periods as described in the premium payment schedule, your coverage will be immediately terminated and may not be reinstated. Your COBRA rights and protections will be forfeited as result of failure to pay premiums timely.

For Kaiser Permanente Coverage: If you elect to continue your Kaiser Permanente coverage, as a qualified beneficiary you are responsible for the full applicable premium payment for the coverage selected, which will include a $2 administration fee. To elect continuation of your Kaiser Permanente coverage, you must complete the COBRA Medical Plan Enrollment/Change Form that will be sent to you and mail it to the address below:

Kaiser Permanente Medical Care Program
California Service Center
P.O. Box 23127
San Diego, CA 92193-9918

After your enrollment form is received, Kaiser Permanente will mail you a monthly statement to make your premium payments. The statement will have preprinted information regarding your account number and the amount due each month. Kaiser Permanente COBRA premiums are due on or before the first day of the coverage month. A grace period of not more than thirty (30) days is provided to ensure that premiums are received. If payment for a specific monthly period is not received within the thirty (30) day grace period, coverage will be retroactively cancelled back to the last date for which coverage was paid.

Kaiser Permanente COBRA premium payments must be made by check or money order made payable to Kaiser Permanente. Mail all Kaiser Permanente COBRA premium payments to the address on the monthly statement provided by Kaiser Permanente. Document the date that the premium is mailed and call Kaiser Permanente at (800) 464-4000 within ten days to ensure that the premium was received. If premiums are not postmarked within the required premium periods as described above, COBRA rights and protections will be forfeited.

For Health Net Coverage: If you elect to continue your Health Net coverage, as a qualified beneficiary you are responsible for the full premium payment for the coverage selected, which will include a 2% administration fee. To elect continuation of your Health Net coverage, you must complete the COBRA Medical Plan Enrollment/Change form that will be sent to you and mail it to the address below:

Health Net
DP COBRA Membership Administration
File # 52630
Los Angeles, CA 90074

After your enrollment form is received, Health Net will mail you a monthly statement to make your premium payments. The statement will have pre-printed information regarding your account number and the amount due each month. Premiums for Health Net COBRA coverage are due on or before the first day of the coverage month. A grace period of not more than thirty (30) days is provided to ensure that premiums are received. If payment for a specific monthly period is not received within the thirty (30) day grace period, coverage will be retroactively cancelled back to the last date for which coverage was paid.

Health Net COBRA premium payments must be made by check or money order made payable to Health Net. Mail all Health Net COBRA premium payments to the address on the monthly statement provided by Health Net. Document the date that the premium is mailed and call Health Net at (800) 828-2525 to ensure that the premium was received. If premiums are not postmarked within the required premium periods as described in the premium payment schedule, then COBRA rights and protections will be forfeited.

For ALL plans:

COBRA premiums must be paid on a monthly basis. A daily rate will be used to determine premiums for any partial months of coverage in order to ensure that you receive both continuous coverage and the exact length of coverage as provided for by law. This daily rate will typically be used to determine the premium for your first and last months of coverage. For example, if due to your qualifying event, your health and welfare plan coverage ended on July 21, your COBRA coverage would begin on July 22. The premium for your first month of COBRA coverage would be for 10 days of coverage and would be calculated by multiplying the daily rate by 10.

All premiums, except those amounts for Kaiser Permanente or Health Net coverage, must be paid by check or money order payable to the County of San Bernardino. Premiums for Kaiser Permanente or Health Net coverage must be paid by check or money order payable to the appropriate company as described above. Any person or entity can pay COBRA premiums for a qualified beneficiary; however, it is the qualified beneficiary's responsibility to insure that the payment is made on a timely basis.

Your first COBRA premium can be made in small partial payments or in one payment; however, the balance of the first premium must be received within 45 days of your COBRA election. This first premium will include all applicable premiums for coverage back to the loss of coverage date through the end of the month in which the first premium payment is made.

After the first payment, you are responsible for insuring your premiums are paid in accordance with the premium payment schedule. You will not receive any further reminders or statements from the County. No partial or late payments will be accepted after payment of the first premium, which is due 45 days following the election of benefits.

Length of Continuation Coverage

18 Months

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. A qualified beneficiary is any individual who, on the day before a qualifying event, is covered under the group health and welfare plans maintained by the County of San Bernardino by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of the covered employee.

Social Security Disability — The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Employee Benefits and Services Division within 60 days after the date of the disability determination and before the original 18 months of COBRA continuation coverage expire. This notice can be made by any of the qualified beneficiaries. If the qualified beneficiary is a newborn or adopted child who is added to a covered employee's COBRA coverage, then the first 60 days of continuation coverage for the newborn or adopted child is measured from

the date of the birth or the date of the adoption. If a copy of the disability determination is not provided to the Employee Benefits and Services Division within this timeframe, then the additional 11-month extension of COBRA coverage will not be provided.

Each qualified beneficiary has independent election rights to this extension. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended and the disabled qualified beneficiary has elected the extension, then the applicable premium rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at the 102% level. It is also the responsibility of each qualified beneficiary to ensure that the Employee Benefits and Services Division is notified within 30 days if a final determination is made that the individual is no longer disabled.

Secondary Events — Another extension of the above mentioned 18 or 29 months continuation period can occur, if during the 18 or 29 months of continuation coverage a second qualifying event takes place (for example a death or divorce). If a second event occurs, then the original 18 or 29 months of continuation coverage can be extended to 36 months from the date of the original qualifying event. Only those individuals who were qualified beneficiaries under the health and welfare plans in connection with the first qualifying event and who are still qualified beneficiaries at the time of the second qualifying event are eligible for this extension. If a second event occurs, it is the qualified beneficiary's responsibility to notify the Employee Benefits and Services Division in writing within 60 days of the second event and within the applicable 18 or 29 months of original COBRA coverage. In no event, however, will continuation coverage under COBRA last beyond 36 months from the date of the event that originally made the qualified beneficiary eligible for COBRA coverage. Effective January 1, 2000, a reduction in hours followed by a termination of employment will not be considered a second event for COBRA purposes.

36 Months

If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under the group health plans maintained by the County, then each qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Assembly Bill 1404: Extended continuation period. Effective September 1, 2003, all health plans must offer individuals who have exhausted their initial 18 months (or 29 months for a disability extension) of COBRA or Cal-COBRA continuation coverage the ability to extend the coverage up to 36 months. This only applies to individuals who **begin** COBRA or Cal-COBRA on or after January 1, 2003. To obtain the extended coverage, you must notify the health plan in writing no later than 30 days before the end of the initial 18-month (or 29-month) COBRA or Cal-COBRA period.

New Dependents and Open Enrollments

If, during the applicable period of COBRA coverage, an employee who elected continuation coverage acquires new dependents (such as through marriage), the new dependents may be added to the coverage according to the rules of the plan. However, the new dependents do not gain the status of a qualified beneficiary and will lose coverage if the qualified beneficiary who added them to the plan loses coverage.

An exception to this is if a child is born to or if a child is placed for adoption with an employee

who has elected continuation coverage. If the newborn or adopted child is added to the covered employee's COBRA continuation coverage, then unlike a spouse or stepchildren, the newborn or adopted child will gain the rights of all other "qualified beneficiaries." The addition of a newborn or adopted child does not extend the 18 or 29 months coverage period. Plan procedures for adding new dependents are available by calling the Employee Benefits and Services Division. Premium rates will be adjusted at that time to the applicable rates.

In addition, should an Open Enrollment period occur during your COBRA continuation period, we will notify you of your Open Enrollment rights as well. If an Open Enrollment period occurs, each qualified beneficiary will continue to have independent election rights to select any of the options or plans that are available to similarly situated non-COBRA plan participants.

California Continuation Rights

Employees who are 60 years of age or older on the date employment ends and who have worked for the employer for at least five (5) years prior to the date of termination of employment are eligible to elect to continue benefits for himself or herself and for any spouse beyond the date COBRA coverage normally ends. The extension lasts until the earliest of:

- The date the individual attains age 65;
- The date the employer ceases to offer any group health plan;
- The date the individual becomes covered under another group health plan, regardless of whether the coverage is less valuable than the extended coverage;
- The date the individual becomes entitled to Medicare;
- For a spouse, five (5) years from the date the former employee's employment ended.

All of the other COBRA terms and conditions apply during the extension, except that coverage of children is not allowed. To qualify for the extension, the individual must have been eligible for and elected COBRA continuation coverage and must not have exhausted their continuation coverage. To continue health care coverage pursuant to this provision, the individual must elect to do so by notifying the Employee Benefits and Services Division in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end.

In general, the premium charge for this special extension period is 213% of the current premium rate. In addition, the extension is contingent upon the timely submission of premium payments.

Cancellation of Continuation Coverage

COBRA continuation coverage will end prior to the expiration of the applicable 18, 29, 36, or 60 (in the case of a spouse covered under the California Continuation Rights extension) months of continuation coverage for any of the following reasons:

- The County ceases to provide any group health plan to any of its active employees;
- Any required premium for continuation coverage is not paid in a timely manner;
- A qualified beneficiary becomes, after the effective date of election, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to (or is satisfied by) such beneficiary by reason of the Health Insurance Portability and Accountability Act (HIPAA) of 1996;

◆ A qualified beneficiary becomes, after the date of election, entitled to Medicare;
◆ A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made finding that the qualified beneficiary is no longer disabled (first day of the month after 30 days from the final determination);
◆ A qualified beneficiary notifies the County they wish to cancel continuation coverage;
◆ For cause, on the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA participants.

Certificate of Health Insurance Portability

Your Certificate of Health Insurance Portability will be mailed separately to your home address. It will detail the amount of time you have been covered under the County's group health insurance plan(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the time covered under the County's group health plan (including COBRA coverage, if elected) may be used to reduce a new health plan's pre-existing condition period. For example, if you were covered under the County's health plan for 10 months, including COBRA coverage, and your new health plan has a 12 month pre-existing condition clause for new enrollees, the new plan would subtract 10 months from the 12 month pre-existing condition period. However, for your coverage under the County's plan to be counted under a new health plan, there must not be a break in coverage for more than 63 days from the time coverage under the County's plan (including COBRA coverage, if elected) ceases to the date of enrollment in your new plan.

Questions regarding a new health plan's pre-existing condition period and the impact HIPAA will have should be directed to your new health plan. If you obtain other insurance, present the Certificate of Health Insurance Portability to your new health insurance plan and they will determine if any benefits are available to you in this matter.

If you elect COBRA coverage, an updated Certificate of Health Insurance Portability will be sent to you when your COBRA coverage ceases. If you lose or do not receive the above-mentioned certificate, one can be requested up to 24 months from the date coverage ceases by calling (909) 387-5552.

How to Get in Touch with a COBRA Representative

By telephone:

Call the Human Resources Department, Employee Benefits and Services Division at (909) 387-5552.

or write to:

COBRA Plan Administrator
County of San Bernardino
Human Resources Department
Employee Benefits and Services Division
157 W. Fifth Street, First Floor
San Bernardino, CA 92415-0440

Contact Information

	Address	Phone	Web Site
Board of Retirement	348 W. Hospitality Lane, Third Floor San Bernardino, CA 92415-0014	1-909-885-7980 1-877-722-3721	www.sbcera.org
Employee Benefits and Services	157 West Fifth Street, First Floor San Bernardino, CA 92415 Interoffice Mail Code: 0440		http://countyline/hr/benefits www.sbcounty.gov/hr/benefits
	Employee Benefits and Services Representatives:		
	AD&D	1-909-387-9675	
	Blue Cross	1-909-387-9675	
	COBRA	1-909-387-5552	
	Delta Care	1-909-387-9674	
	DeltaPreferred	1-909-387-9674	
	Kaiser Permanente	1-909-387-5556	
	Life Insurance (Term and VUL)	1-909-387-9675	
	Health Net	1-909-387-5831	
	or	1-909-387-9674	
	Health Net Vision	1-909-387-5556	
Providers			
AD&D	(Contact your Payroll Clerk or Employee Benefits and Services)	1-909-387-5787	
Blue Cross	P.O. Box 4089 Woodland Hills, CA 91365	1-800-288-2539	www.bluecrossca.com
Delta Care	12898 Towne Center Drive Cerritos, CA 90703-8546	1-800-422-4234	www.deltadentalca.org
DeltaPreferred	P.O. Box 7736 San Francisco, CA 94120	1-800-765-6003	www.deltadentalca.org
Kaiser Permanente	Kaiser Foundation Health Plan P.O. Box 7102 Pasadena, CA 91109	1-800-464-4000	www.kp.org
Health Net	P.O. Box 9103 Van Nuys, CA 91409-9103	1-800-676-6976	www.healthnet.com
Health Net's Behavioral Health (Managed Health Network)		1-888-426-0030	
Health Net Vision		1-800-880-3135	www.dv.healthnet.com
Voluntary Term Life *(The Hartford)*	(Contact your payroll clerk or Employee Benefits and Services)	1-877-ONE-HART 1-909-387-5787	
Variable Universal Life *(AGB)*	362 N. Frank Lloyd Wright Blvd., Ste. 1000 Scottsdale, AZ 85260	1-866-956-1876	www.sbennett@agbusa.com
San Bernardino County Public Employees Association (SBPEA)	433 N. Sierra Way San Bernardino, CA 92410	1-909-889-8377 1-877-312-3333	www.sbpea.com
San Bernardino County Safety Employees' Benefit Association (SEBA)	555 North "E" Street San Bernardino, CA 92401	1-909-885-6074 1-800-655-7322	www.seba.biz

Notes

County of San Bernardino
Human Resources Department
Employee Benefits & Services Division
157 West Fifth Street, First Floor
San Bernardino, CA 92415-0440

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